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World Vision Relief & Development, Inc.

**WVRD/Honduras
Final Evaluation Report
San Miguel SURVIVAL PROJECT
Tegucigalpa, Honduras
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LIST OF ACRONYMS

ALRI	Acute Lower Respiratory Infection
ASHONPLAFA	Honduran Association for Family Planning
CDD	Diarrheal Disease Control
CEFASA	Family Health Survey
CESAMO	<i>Centro de Salud Medico</i> , Medical Health Center
COHASA	Honduran/German Food Society
CS	Child Survival
CSP	Child Survival Project
CV	Community Volunteer
EPI	Expanded Program on Immunization
FP	Family Planning
IEF	International Eye Foundation
HDSC	Health and Development Subcommittee
HIS	Health Information System
IGA	Income Generating Activity
K/P	Knowledge/Practice
L	Lempira, Honduran Unit of Currency
M/C	Mother/Caretaker
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernment Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
TT	Tetanus Toxoid
VAC1	Daily Vaccination Forms
VAC2	Vaccination Reports
WCBA	Women of Childbearing Age
W/H	Weight-for-Height
WR	World Relief
WVH	World Vision Honduras
WVRD	World Vision Relief & Development
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

The child survival project was implemented by World Vision/Honduras in an urban area of Tegucigalpa, Honduras from October 1992 through September 1995. The counterpart agency was the San Miguel Health Center. The project served in all ten projected *colonias*, with a total population 44,758. The effective coverage as determined by the population directly served by the 280 Health Volunteers was of 2,006 children under two years of age (68% of this age group) and 4,467 women of childbearing age (38% of this age group).

The project focused on fifteen child survival interventions. The interventions that achieved the greatest impact were, vaccination of mothers against tetanus, breastfeeding children under two years of age, and treatment of acute respiratory infections at the health center.

In a few interventions the project did not have any impact. These are interventions where the objectives were not met and demonstrated five percentage points or less change from the baseline. The interventions were, family planning, exclusive breastfeeding of children under 6 months of age, mothers knowledge of how to prepare and use ORS and giving children with diarrhea oral rehydration solution.

When the mothers were asked about the benefits of the project, their most highly valued responses were that the Health Volunteers were readily available, they learned how to care for their sick children and they have more effective referrals at the Health Center. An important implication is that the project improved these mothers' access to health care. Another positive outcome was that Health Volunteers, who are mostly women, grew in self-confidence and stature in their communities. There was positive growth in relationships with the staff at San Miguel Health Center. By the time of the final evaluation there was mutual respect between the health center and project staff. In the management area a positive outcome was the organization of the Health Information System (HIS). Although there was a delay in implementing it, the existing system is excellent.

The Project experienced some substantial delays which limited the population served and length of time that child survival interventions were implemented. The primary cause was the high turn-over rate of project staff. One consequence was that the staff did not develop a coherent sense of direction until after the mid-point of the project. Another consequence was that the Health Volunteers were minimally effective until Year Three.

The evaluation report contains a long list of lessons learned, but by far the most valuable, which is fundamental to community development, is that planning must be done with the counterpart agency and community leaders.

WVRD/Honduras
FINAL EVALUATION
SAN MIGUEL CHILD SURVIVAL PROJECT
October 1, 1992 - September 30, 1995

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

The project focused on fifteen child survival interventions. For the purpose of this evaluation the interventions have been organized into seven sets of interventions: Immunizations, Growth Monitoring, Maternal Health, Nutrition, ARI, Diarrhea Control, and Dengue Fever Prevention. The interventions are listed below by the sets of interventions. The charts included data from the baseline survey, the final survey (see Appendix A) and the targeted objective for each intervention.

IMMUNIZATION

INTERVENTION	BASE	FINAL	OBJ.
Children under 2 completely immunized	77	86	90
Mothers with children under 2 know the age for giving Measles vaccination	46	51	95

GROWTH MONITORING

INTERVENTION	BASE	FINAL	OBJ.
Volunteers creating and using growth curves	xx	98	xx

MATERNAL HEALTH

INTERVENTION	BASE	FINAL	OBJ.
Mothers who wish to do so, using family planning	45	49	15
Mothers with prenatal card	42	49	85
Mothers who have had a child in the last year, with at least 2 doses of TT	61	95	80

NUTRITION

INTERVENTION	BASE	FINAL	OBJ.
Children under 2 given breast milk	64	78	80
Children under 6 months exclusively given breast milk	27	22	70

ARI

INTERVENTION	BASE	FINAL	OBJ.
Promoters know the signs of pneumonia	xx	100	95
ARI treated at the Health Center with antibiotics	50	97	70
Mothers recognize rapid breathing as a sign of pneumonia	68	83	78

DIARRHEA CONTROL

INTERVENTION	BASE	FINAL	OBJ.
Mothers know how to prepare and use ORT	57	57	90
Children with diarrhea treated with ORS	26	23	80
Children with diarrhea not treated with antibiotics	34	41	95

DENGUE FEVER PREVENTION

INTERVENTION	BASE	FINAL	OBJ.
Household dwellers know at least 2 dengue prevention measures	xx	64	50

Of the above interventions, those that met or exceed the targeted objectives in the final survey are listed as follows:

ACCOMPLISHED OBJECTIVES

INTERVENTIONS	
<ul style="list-style-type: none"> • Children completely vaccinated • Volunteer Health workers creating and using growth curves • Mothers who have had a child in the last year, with at least 2 doses of TT • Children under 2 given breast milk • ARI's treated in the Health Center • Promoters know the signs of pneumonia • Household dweller know at least 2 dengue prevention measures 	

Another aspect of the project's accomplishments is to assess the degree of change from the baseline to the end-of-project survey. Even though some objectives did not meet the target, significant progress was achieved. The objectives that demonstrated positive change are as follows:

CHANGE FROM BASELINE TO FINAL SURVEY

INTERVENTION	PERCENTAGE POINTS OF CHANGE
ARI's treated at the Health Center	47
Mothers with TT vaccination	34
Children under 2 being breastfed	14
Children completely vaccinated	9
Mothers with prenatal control cards	7
Children with diarrhea not treated with antibiotics	7

Mothers know age of measles vaccination	5
Women using family planning	4

One way to assess the project's impact is to identify the interventions that both met project objectives and showed significant change (>10%) from the base line to the end of the project. The following chart presents the interventions that had the most substantive impact.

INTERVENTIONS WITH MOST SUBSTANTIVE IMPACT

INTERVENTIONS
<ul style="list-style-type: none"> • Mothers with TT vaccination • Children under 2 being breastfed • ARI's treated at the Health Center

In a few interventions the project did not have any impact. These are interventions where the objectives were not met and demonstrated five percentage points or less change from the baseline. The interventions with no impact are listed in the following chart.

INTERVENTIONS WITH NO IMPACT

INTERVENTIONS
<ul style="list-style-type: none"> • Women using family planning • Children under 6 months exclusively breastfed • Mothers know how to prepare and use ORS • Children with diarrhea being given ORS

External factors affected the level accomplishment of some of the interventions. Mothers' ability to exclusively breastfeed their babies up to six months of age is affected by Honduras' economic crisis. Mothers increasingly have to leave home to find work. Additionally, many mothers are single parents and have to work outside the home to sustain their families. No statistics exist regarding the number of single parents. The evaluation team, however, asked four Health Volunteer Coordinators from different *colonias* if more than half or less than

half of the mothers in their neighborhood were single parents. Three of the four stated that over half of the homes were headed by a single parent. This factor significantly affected the project staff and Volunteers' effectiveness in promoting exclusive breastfeeding.

The set of interventions regarding diarrhea was the area where the project had the least impact and the most inconsistent survey findings. Mothers showed no increase in their knowledge of preparing and using ORS and data on percent of children being given ORS also showed no increase. The data for these objectives, however, related specifically to question #18 in the Knowledge and Practice survey. On the other hand, in the final survey 67% of the mothers surveyed reported that they gave the same or more fluids when their children had diarrhea. This represented an increase of 9% from the baseline. This datum was not included in the objective, but it does have an effect on diarrhea treatment. Countering this finding, however, is the report in the survey documents that there was a reduction from 59% to 47% of mothers who gave the same or more solids to their children with diarrhea. (Question #16 in the survey.)

Educators and project staff need to work hard to find a balance between the factors of simplicity, accuracy and cultural relevance in teaching mothers about home treatment of diarrhea. For example, a factor that affected diarrhea treatment is the number of names being used for oral rehydration. This caused confusion among mothers when they talk about rehydration. *Litrosol, suero oral, suero casero, agua, agua de arroz* all refer to different methods of oral rehydration yet some of them were used interchangeably. The message regarding oral hydration would probably have been more effective if the terminology would have been simpler and based on terminology used by the people.

Coverage

The project served in all ten intended *colonias*, with a total population 44,758. The effective coverage as determined by the population directly served by the 280 Health Volunteers was of 2,006 children under two years of age (68% of this age group) and 4,467 women of childbearing age (38% of this age group). It should be noted that in the last year the project staff achieved a substantial increase in the coverage. At the end of Year Two the percentage of children under two who were being monitored by Health Volunteers was less than 25%. The reason for the rapid increase was the restructuring of the volunteers' assigned service areas according to blocks that was implemented during Year Two. At this time the project staff made growth monitoring the axis of the project. Each Health Volunteer was assigned 10 children under two on their block, or an adjacent block, and asked to conduct monthly growth monitoring and immunization surveillance for those children. Once the Health Volunteers fully organized

themselves and began working in their assigned areas, they became dramatically more effective. The strategy change bore positive results in Year Three.

The population that was not directly served by the Health Volunteers was reached through mass communication programs, vaccination campaigns in cooperation with the San Miguel Health Center, and weekly neighborhood health talks given by the Health Volunteers.

Unplanned Positive Outcomes

The evaluation team interviewed mothers, Health Volunteers, Health Volunteer Coordinators and the San Miguel Health Center staff that work in the community. The team used a modified Nominal Group Technique to interview these various groups. The interview participants identified and discussed the project's accomplishments and then each participant gave a numerical value to each response. The accomplishments with the highest average score were designated as the most important accomplishments. This process enabled the interviewees to place a value on their responses to the group-interview questions.

When the mothers were asked about the benefits of the project, their most highly valued responses were that the Health Volunteers were readily available, they learned how to care for their sick children and they have more effective referrals at the Health Center. An important implication is that the project improved these mothers' access to health care.

When the Health Volunteers and the Health Volunteer Coordinators were asked about the accomplishments of the project, their most highly valued responses were that they felt good about themselves because they were trained, they had acquired a vocation for service to their communities, and they now had a leadership role. Thus another positive outcome was that Health Volunteers, who are mostly women, grew in self-confidence and stature in their communities.

These two groups were also asked about their motives for volunteering. Their most highly valued responses were that the work made them feel useful, it was satisfying to learn, and it was gratifying to serve the community. These findings highlight the importance of internal motivation for volunteer work. The internal motivators identified by the women are much more powerful and sustaining than external items such as tee-shirts, food donations, etc. Whether intentionally or not, the project staff were effective in mobilizing the Health Volunteers for service.

Another area in which there was a positive outcomes was in relation to the San Miguel Health Center. The project staff struggled for three years to establish

a good working relationship with the health center. Both sides contributed to the difficult working relationships, however, relationships dramatically improved with the arrival of Dr. Pinel in January 1995 as Health Center Director. By the time of the final evaluation there was mutual respect between the health center and project staff. When the health center staff were asked to rate the accomplishments of the project, their highest valued responses were, logistic support of the health center, coordination between the health center and the project and expanded coverage by the Health Volunteers.

In the management area a positive outcome is the organization of the Health Information System (HIS). Although there was a delay in implementing it, the existing system is excellent. It has an organizational structure that links evaluation indicators, source of data, collection methods and forms, and frequency of collection. The structure provides direction and discipline to the system so that only useful and collectable data are in the system. Unlike most systems that the evaluation team has seen, it did not clog the system with unnecessary and unusable data. The data are accessible and are fed back to Health Volunteers and staff according to the schedule in the organizational chart. As a means of testing the system, the evaluation team asked for data on the percent of women supervised by the Health Volunteers who are exclusively breastfeeding. The HIS coordinator produced the data from the previous month in less than five minutes.

The only limitation to the system was that the database in the HIS only covered families that are directly supervised by the Health Volunteers. These data do not necessarily represent the population as a whole. Consequently the system cannot indicate progress towards accomplishing the project's measurable objectives. A recommendation that was made to the staff was to complement the HIS with a system of local rapid assessments of sets of measurable indicators, one set at a time. For example, the staff could assess progress in the area of diarrhea control indicators at in one quarter, then in the next quarter assess ARI indicators. A rotating system could be set up so that every 12 months the same set of indicators was assessed again. This would give project staff regular data on their progress without having to wait for the final survey to know where they stand.

Another area in which the project contributed to health development was in sanitation and potable water. World Vision/Honduras helped six *colonias* construct 57 latrines and help two other *colonias* repair existing latrines. It contributed PVC pipe and accessories for water projects in two *colonias*. The water projects were joint projects between World Vision, the community and city government.

The project staff found a valuable local resource in the national school of nursing. The project coordinator was able to involve nursing students in helping to do on-the-job training of Health Volunteers. The nursing students were a valuable

resource for speeding up the process of getting the Health Volunteers going in their work with mothers and children in their assigned blocks. The project in turn, provided the students with field experience that they would otherwise not have been able to acquire. Both organizations benefitted greatly from the relationship.

The project staff assisted a group of Health Volunteers in one *colonia* to establish a community pharmacy. World Vision/Honduras helped the group capitalize their initial stock of medicines. Since then the Health Volunteers have been able to sustain their operation through the sale of medicines. Project staff have provided training in handling medicines and in managing the business. The group has not generated high profits, but it has been enough to keep them going. The greatest benefit of the project is the pride that the women have in running their own business. The potential exists for more local pharmacies. This kind of project has good prospects for contributing to community-based sustainability in future child survival programs.

Project Limitations

The project had a number of limitations which reduced its effectiveness. The Project experienced substantial delays which limited the population served and length of time that child survival interventions were implemented. While the project did facilitate change, it did not accomplish all that it could have. The greatest negative factor was in the turnover of personnel. In the first year there was a 60% turnover in project personnel, including the Director and Project Coordinator. One consequence was that the staff did not develop a coherent sense of direction until after the mid-point of the project. Another consequence was that the Health Volunteers were minimally effective until Year Three.

The Detailed Implementation Plan (DIP) was affected by the change in personnel. After the new staff replaced departing staff, they felt that the project was not well organized. The roles and responsibilities of the Health Volunteers were not well defined and there was no strategy for serving the intended population. It was the new staff team that organized the Health Volunteers to target specific blocks and assigned each Volunteer to provide monthly growth monitoring care for ten children under 2 years of age. The new leadership articulated and adopted the strategy of making growth monitoring the focal point of child survival interventions. The new leadership did a good job in organizing the project, however, valuable time was lost in the process. Another consequence of the change in leadership and the reorganization was that many of the activities in the DIP were not carried out. Some of the planned activities that were not implemented were: village banks, family gardens, a pre-payment insurance system, community development committees, health teaching in local schools, a coordinating committee with the Health Center and most of the elements of the

original sustainability plan. (Refer to Section II.C. on page 13 for a description of the current sustainability plan.) In the end it was fortuitous that the project staff did not attempt to implement the above activities because it would have diverted the staff from implementing the basic components of the project.

Another key turnover in personnel was the change in the HIS coordinator. The replacement coordinator did not have any prior experience in information management, thus he had to learn on the job. This delayed the implementation of an effective HIS. The project did organize a workshop on HIS, but it was in the second year. As a result of these delays, HIS data are only available from the third year.

The project staff also have had difficult relationships with the San Miguel Health Center. Two factors influenced the relationship. One, the original project staff did not consult the Health Center staff in the design of the DIP. They were informed after the plan was written. This created resentment on the part of the community-level staff at the health center and as a result there was minimal collaboration with the project for at least the first year and a half. Second, the health center has had three directors in three years. The project staff had to start over with each director. It was not until the third year that good relationships and the concomitant collaboration were established between the project and the health center.

The original Health Volunteer training strategy was not effective. Valuable time was lost until project staff were able to devise a more effective strategy. In the original strategy, local women were trained as Health Volunteers simply on the basis of whoever was interested being trained. Consequently there was no consistency in who attended from training session to training session. Additionally, Health Volunteers were not given any direction in deciding who they should serve and what they specifically should do. This strategy had damaging consequences for community participation. An expectation was created that the project would do things for people. When the project staff made the commitment to change their strategy, it was difficult to overcome the dependency attitude created by the original strategy.

B. Project Expenditures

The project was under budget by 16.8%, primarily due to devaluations of the local currency. Financial management was effective in that the project expenses did not exceed the budget. The travel/per diem category was overspent by \$35,803. The excess expense is due to the training, over and above what was stipulated in the DIP, which was provided to the community personnel in an effort to provide a higher quality of service.

Due to the availability of excess funds, the project staff requested, and were granted an unfunded extension for six additional months. The financial information is outlined in the pipeline analysis for the project (see Appendix B).

C. Lessons Learned

1. Project plans must be developed in collaboration with the local health center and community leaders. This is a basic tenet of community development, but unfortunately PVO's at times believe that they do not have time to do so because pressure of completing a project in three years. A tendency exists, as in this project, to write the plan and later discuss it with the health center and community leaders. When the project simply informed the health center staff of what they had to do to cooperate with the project they found considerable resistance. It took two years to overcome their resistance. On the community's side, because there was no attempt to involve local leaders in planning, the project was never able to establish solid linkages with existing community organizations. This will negatively affect the project's sustainability. In the future project staff should begin by developing relationships with community government (*Patronatos*), mothers clubs, cooperatives, etc., and involvement them in writing the DIP. The same applies for the local health center staff.
2. The HIS should be developed and implemented in cooperation with the health center, including sharing responsibility for managing the system. The current HIS coordinator is beginning to do this now, and regrets that he did not do it at the beginning. It would have taken more time at the beginning to work out relationship issues, train, and equip the health center, but in the long run the system would have been more efficient. The sustainability of the HIS would also have been strengthened by the health center having a sense of ownership in the system. This evaluator recognizes that it is not always possible to develop this kind of close working relationship between a PVO and a health center. The concept, however, is critical to good development practice and to sustainability and thus it is worth making the effort to do so.
3. Health center staff need to be trained in child survival strategies and interventions. The work of the health center is oriented towards case management of patients, while child survival is population based and focused on promotion and prevention. Training health center staff from the beginning would have helped them understand the project and could have reduced some of their initial resistance. It could also have countered the initial perception that the project was in direct competition with the health center.

4. Health Volunteers should be trained using adult education strategies, rather than lectures to large groups. People do not learn the practical child survival interventions by listening to someone talk about it, they learn best by doing. When the project staff applied this lesson half way into the project, they observed a substantial increase in the effectiveness of the Health Volunteers in applying what they had learned.
5. Health Volunteers should be selected by the communities that they serve, rather than being self-selected. Project staff should consult with community leaders and health center staff in developing criteria for selection, then let the community make the selection.
6. The project design in the DIP needs to be simple and clearly focused on key child survival interventions. The design for this project was too complex and included too many activities, especially considering that it was World Vision/Honduras' first experience with a child survival project. The project staff were at a loss in knowing how to manage the multiple activities planned in the DIP. In the end many planned activities were not implemented, to the benefit of the project's effectiveness. (Refer to the Project Limitations section on page 8 for a listing of planned activities that were not implemented.)
7. The project design should have a central focus on a specific child survival intervention, or a particular set of interventions. In the case of this project, it took a leap forward when the staff decided to make growth monitoring its central focus. It gave staff, Health Volunteers and mothers a concrete, straight forward activity in which to begin. Growth monitoring in turn provided the means for monitoring children's vaccinations, teaching mothers with children at risk about nutrition, diarrhea control and ARI. All of the child survival interventions targeted in the project were implemented with growth monitoring as the point of entry. Another advantage was that growth monitoring gave the Health Volunteers tools to work with that are tangible and that create a positive impression. They had instant prestige when they set up the scales, weighed the babies, helped the mothers record the weight in the growth monitoring charts, and on the spot identified babies who were at risk because of being under weight. Finally, another advantage of growth monitoring was that it kept the Health Volunteers in monthly contact with mothers. While they had a regular sequence of home visiting, it was not always possible to catch all of the mothers at home. They were reassured that at least they would see the mothers at the monthly weighing time. Eventually the Health Volunteers developed on their own the strategy of concentrating their home visits on mothers who missed the monthly growth monitoring sessions.

8. The project design should include a specific plan for structuring the relationship between health volunteers and the community. In the case of this project, the Health Volunteers did not function until they were each assigned to work with mothers in a specific block. Additionally, the number of mothers or families assigned to each volunteer needs to be small enough for them to effectively manage. Project staff need to remember that they are volunteering their time. The project would have gotten off to a faster start if it would have had such a strategy from the beginning.
9. The plan for sustainability should be implemented from the beginning of the project and implemented in cooperation with the local health center and relevant community organizations. In the case of this project, the staff who took over from the original leaders did not realize the importance of the sustainability plan until after the mid-term evaluation. They found it difficult to implement the original sustainability plan because the 15 months left to the end of project did not give them enough time to implement it. Instead the staff wrote a new plan, in consultation with the San Miguel Health Center, Health Volunteer Coordinators and the School of Nursing.
10. The core management responsibilities should be implemented within an integrated management plan. In this project the most important activities were the training plan, the HIS, the sustainability plan, administration and financial management. The lack of an integrated management plan resulted in certain areas being implemented without considering the implications for other areas. Consequently staff wasted time in backtracking. For example, the training plan did not incorporate the needs of the HIS. Time and data were lost because Health Volunteers did not keep data on growth monitoring and vaccinations from the beginning. Additionally, when it came time to implement the HIS, staff had to take the Health Volunteers from time in the community to train them all over again in how to use the HIS.
11. An integrated management plan, with effective use of the HIS, will enable project staff to monitor the progress of the project and make opportune decisions regarding its direction. The current staff felt that at times they were off track and did not know it as soon as they would have liked. They wished that more time would have been spent at the beginning developing a coherent management plan. For example, project staff believe that they would have been more efficient if the training plan and the set up and training for the HIS would have been coordinated.
12. Project staff should invest significant time at the beginning of the project in community organization. The staff believe that they started right away with education without effective support from the community. In the end it was

counterproductive because the right people were not trained. They lost more time than they gained by starting the Health Volunteer training right away.

13. Coordination with other PVO's and government agencies can enhance the project's effectiveness. This lesson was especially true in regard to the School of Nursing. The nursing students were valuable resources in helping the Health Volunteers get started. Other organizations that provided specialized help in the project were the La Leche League and ASONPLAFA (Family Planning) and the International Eye Foundation.

II. PROJECT SUSTAINABILITY

A. Community Participation

The key community-based resource for sustaining the project are the Volunteer Coordinators. These are Health Volunteers who have been selected to help supervise and coordinate the work of their peers. The Volunteer Coordinators have begun to receive additional training in supervision and in managing the HIS. To the extent that they are able to formalize an organizational structure and maintain it, then there will be some degree of community participation. Other resources for community participation such as *Patronatos* have not been cultivated in this project. The project staff are now working on expanding relationships in the community, but these will have a reduced impact because of the little time that is left for doing so. The evaluator recommended that the Volunteer Coordinators serve as the foundational community organization for the sustainability plan. Project staff should assist them in establishing a well defined organizational structure and in developing means of financial support through such mechanisms as community pharmacies and village banks. It is encouraging to note that a group of Coordinators have already organized a community pharmacy, which after nearly a year of operation is turning a small profit.

If the Volunteer Coordinators can create and maintain a reasonable level of organization they will be a critical factor in sustaining child survival interventions. It will be essential that the health center staff recognize and give them moral support following World Vision's withdrawal. No matter how well the Volunteers Coordinators organize themselves, they will not be able to continue without it.

A representative group of Volunteer Coordinators were asked to identify resources that they had for continuing the project. The two most highly valued resources were their own self-confidence and their fund of knowledge. They also referred to the educational materials on hand and the support of mothers and the health center staff.

The evaluation team also asked them about additional help that they needed in order to continue. The most highly valued help that they needed was in maintaining their equipment, additional educational materials and continued referral support from the health center. It will be important that these support items be included in the sustainability plan that is being finalized. (Refer to Section II.C, page 15.) These are concrete actions that the proposed Child Survival Coordinating Committee can perform in support of the Volunteer Coordinators.

B. Counterpart Sustainability

The counterpart agency for this project is the San Miguel Health Center. In the group interview conducted by the evaluation team, the health center's community-level staff were asked to identify and rank the resources for, and obstacles to, continuing the project. The most valuable resource by far that they identified was their own training. They felt that they had the knowledge and skills and they would continue the project at least on a minimal level. They stated that their understanding of child survival had shifted from a disease management orientation to a population-based, health promotion orientation. They were pleased by the fact that the project had given them more contact with the community and regarded the Health Volunteers as valuable resources. Most important of all, the Health Center Director stated he was going to assign each field staff member a specific sector for supervising and coordinating the work of the Health Volunteers. According to this plan all of the Health Volunteers would be integrated into the health center system.

This is a critical commitment and is reflective of the good working relationship between the project and the health center. This plan, however, is contingent on the commitment of the Director. When a new director arrives in 1996, that person may not have the same commitment to working with the Health Volunteers. This point of vulnerability could be reduced if at the Regional level a policy would be made in support of integrating Health Volunteers trained by Child Survival projects into local health center management structures.

The obstacles identified by the health center staff were, coordinating the work of such a large number of Health Volunteers, the lack of resources for training and handling referrals from the Volunteers, and the lack of transportation for getting out into the community. These obstacles will slow down the work in the community, but as long as the health center staff have the will and commitment to continuing the project, they should be able to do so at least at a minimal level. They will need encouragement and a periodic boost from events such as child survival continuing education seminars and skills training workshops. These will be invaluable in sustaining their interest and commitment over time.

C. Sustainability Plan

The sustainability plan presented on the next page is different from the one in the DIP. The project began developing it at the end of Year Two. This plan is weakened by the fact that project staff have six month left in which to make it function. It will have to be a high priority for the project staff during the unfunded extension.

The current plan has been written in consultation with the San Miguel Health Center staff, Health Volunteer Coordinators and faculty from the School of Nursing. Other agencies that will be involved are: La Leche League, ASONPLAFA and the International Eye Foundation. Project staff are working on identifying community-based organizations that would be interested in cooperating in the project.

SUSTAINABILITY PLAN

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TO DATE	OUTCOMES TO DATE
1. To coordinate the activities of all the agencies working in health care in support of existing child survival activities.	1.a. Signed agreement among all agencies	1) Six meetings with agency heads to discuss roles and responsibilities 2) Draft agreement written	1) Agreement confirmed with Health Center about roles and responsibilities.
	1.b Create an interdisciplinary team that will supervise implementation of the plan.	1) A workshop for participating PVO's has been held. 2 A follow up workshop has been planned.	1) Representatives of the participating PVO's have been named by their agencies.
	1.c. Organize and train Health Volunteer Coordinators to supervise Health Volunteers.	1) A training plan has been designed for the Coordinators 2) Training in leadership completed. 3) Training in HIS has begun	1) Health Volunteer- Coordinators have been selected and training has begun.
	1.d. Identify and organize community-organizations that will agree to participate in the Child Survival Health Care system.	1) Inventory of community organizations in progress 2) A workshop for community leaders on child survival is being planned	

III. EVALUATION TEAM

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Appendices

Appendix A

Final Survey Report
World Vision Honduras
Child Survival Project VIII

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WORLD VISION -- CSVIII

Final Survey

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EXECUTIVE SUMMARY

A survey on knowledge and practices was conducted in 30 blocks from the San Miguel Sector from August 28 through 30. This work was performed in a cooperative effort of WORLD VISION (WV), Health Center (CESAMO) San Miguel and the technical assistance of the Latin American and Caribbean Bureau (ORALYC).

The goal of the survey was to gather data to evaluate the child survival knowledge and practices of mothers of children under 2 years of age living in the twelve impact communities of the San Miguel Child Survival Project. Additionally, we expected to identify the individuals responsible for the family health needs.

The Child Survival Project FY-95 (CS-VIII) is being implemented by World Vision-Honduras, a local NGO with headquarters in Monrovia, California. The San Miguel Project received a grant in the amount of US\$ 441,000 from USAID (Food and Humanitarian Assistance/Private Voluntary Cooperation/Child Survival Health) and US\$ 264,445 from World Vision International to conduct a Child Survival project from October 1, 1992 through September 30, 1995.

The survey questionnaire was designed by the project's staff based on a standardized questionnaire developed at the PVOs support office in Baltimore, Md. as the product of several experiences on baseline and final project evaluations in developing countries. The methodology has now been standardized, simultaneously reaching WV's goal of training its staff on cluster surveys. Both WV and CESAMO San Miguel field teams received the cluster-surveys training by Dr. Edmundo Osorno. The main goal of this training was to build the capacity of both WV-Honduras and CESAMO San Miguel to perform such studies in order to evaluate the progress of joint projects with minimum or no foreign aid.

The study objectives were accomplished in two weeks. The field team discussed the results extensively in order to provide recommendations for the next implementation Plan.

I. INTRODUCTION

A. Background

In order to understand the interventions of the Child Survival Project in the 12 communities of CESAMO San Miguel, we deemed it important to mention some of the activities that World Vision has accomplished in Honduras.

In 1974, WV emergency projects were introduced in response to the severe damages produced by hurricane Fifi. Five years later, seven projects were opened in the south region of the country due to the drought going on there. At that time all activities were supervised from Guatemala¹.

By de 1992, WV projects ceased being management by foreign personnel and an in-country staff took over the responsibilities¹.

At this point, it is worth mentioning that WV's initial work in Honduras had an emphasis on sponsor-based projects and an incipient component of community development through special funding (not sponsoring). In time and until now the focus of the work is essentially on integral development, instead of just a provision of assistance².

Currently, this line of action has been strengthened by the addition of two strategic elements that WV defines as Strategic Organization and Integral Mission².

Concurrently with what happened with WV in 1988, the Latin American Regional Bureau adopted the Primary health Care strategy with the following components: 1) mother-child care; 2) food and nutrition; 3) water and sanitation; 4) health education; 4) communicable diseases control; 6) Traditional medicine, and 7) regular medicine. All of these came to adjust and strengthen Child Survival interventions in response to the demands of the priority groups.

In an effort to strengthen the implementation of the above mentioned strategies, WV-Honduras has added to its conventional health actions, interventions associated with:

¹Consultation with Mr. Leonel Solís, WV-Honduras Inspector.

²Consultation with Mr. Leonel Solís, WV-Honduras Inspector and Mr. Tomás Moreno, WV-Honduras Accounting Officer.

1. Agricultural Development
2. Formal and Informal Education
3. Environmental Action
4. Woman's development

Currently, WV-Honduras has 108 employees in the country, 34 at headquarters and 74 at the regional offices all over the country. They provide support to 89 community development projects through the children's sponsorship program and 22 development projects in large geographical areas in 15 out of the 18 departments of the country.

In 1990, WV opened a Child Survival project with funding from USAID-Washington in order to design and implement one in the sub-urban communities of Tegucigalpa, namely 12 communities from Colonia San Miguel. Activities started in October 1992.

Key Project Interventions include:

- ° Diarrheal disease Control
- ° Acute Lower Respiratory infections (ALRIs)
- ° Enhanced Programme on Immunization (EPI)
- ° Nutrition, Dengue Fever Control
- ° Family Planning, and
- ° Income generating activities.

In February 1993, a baseline survey was performed in order to determine the knowledge and practices of the target population.

The baseline survey on knowledge and practices was performed by the staffs working for the WV-Honduras Child Survival project, CESAMO San Miguel, SAVE THE CHILDREN and Cooperativa Hondureña Alemana de Seguridad Alimentaria (COHASA) with the assistance of Dr. Marcelo Castrillo from the School of Public Health at Johns Hopkins.

B. Study Objectives of the Final Survey

The population based survey under the cluster sampling methodology is a very useful tool for the collection of follow-up indicators for the Child Survival project. These indicators are associated with rates and vital statistics, data that are associated with the monitoring and evaluation of the project.

Data from this survey will help to assert the indicators for the CS project final evaluation. That evaluation includes level I indicators, Child Survival Indicators and plot their tendency towards the end of the project.

This kind of study was designed to be used as a project management tool as it facilitates the decision making process by presenting the manager with the project's tendencies and progress.

The current study was performed so that we could provide World Vision with the following data:

1. Knowledge of mothers with children under 2 years of age about: a) the most important threats to their children's health, and b) ways to prevent diseases or limit their sequelae. Some of these practices include immunization, proper management of diarrhea, growth monitoring, appropriate weaning and feeding, and management of acute respiratory infections.
2. Mothers' current practices regarding the previously mentioned interventions.
3. Key community groups that could be used to deliver and focus the education messages and the actions.
4. Immunization coverage rates for children under one year of age and also those between 12 and 23 months.
5. Estimate of the diarrheal disease rates, and symptoms compatible with acute respiratory infections within the previous two weeks to the survey, emphasizing on the mothers practices regarding these diseases.
6. Mothers' practices regarding the management of diarrhea and dehydration, as well as the acute respiratory infections.
7. Mothers' practices regarding breastfeeding, regular feeding and weaning.

8. Ante-natal control, who assisted in the delivery and estimate of women using a family planning device.

This data collection will help WORLD VISION-HONDURAS field staff re-direct health related activities through the improvement of follow-up, supervision and evaluation of the project, as well as to be aware of the project's current status. These data will be compared with previous as well as future project evaluations.

Finally, this study is part of a joint effort between the John Hopkins University and USAID so that a standard methodology for the collection of baseline, follow-up/evaluation data is available for Child Survival Projects implemented by PVOs. Because of that, one of the main objectives of this survey was to train World Vision and CESAMO San Miguel's field staffs in the design and implementation of this kind of studies.

The FHA/CSH Bureau at USAID/Washington included such a study as one of the requirements for the baseline, mid-term and final evaluations of Child Survival programs.

The data analysis and the presentation of the final report are considered an integral part of the study, and they are an objective to be fulfilled the first week after the study.

C. Geographical Area and Population

The project's area (12 neighborhoods) has an estimated population of 44,168 inhabitants³.

The impact population is distributed as follows:

° Children between 0 and 11 months:	1,626
° Children under 5 years:	8,137
° Child bearing age women:	11,950

The project's impact area includes the following communities (neighborhoods):

³ Department of Bio-statistics. Honduran Ministry of Health.

Brisas del Valle; 28 de Marzo; La Era; La Travesía; 13 de Julio; La Izaguirre; La Sosa; 30 de Noviembre; La Trinidad; Estados Unidos, San Miguel and La Esperanza.

D. Timeline in Honduras

August 22, 1995

1. Welcome to the group
2. Discussion of the agenda
3. Objectives of the KAP training.
4. Presentation of the methodology.
5. Revision of the questionnaire.

August 23, 1995

1. Summary of the previous day.
2. Interview techniques.
3. Role-play and its discussion.

August 24, 1995

1. Summary of the previous day.
2. Roles assignment
 - a. Core Team
 - b. Supervisors
 - c. Interviews
3. Role-play.

August 25, 1995

1. Instrument Validation.
2. Field test at a community different from the project's.
3. Manual Tabulation.
4. Selection of Clusters.

August, 1995

Actual survey.

September 1-6, 1995

Data tabulation in EPI-INFO

September 8, 1995

Draft Final Report.

September 18, 1995

Presentation of the final evaluation results.

II. METHODOLOGY

A. The Questionnaire

The questionnaire (see annex 2), consists of 48 questions. It was designed to collect information on the Child Survival interventions of World Vision-Honduras. All questions were designed and selected by the project and CESAMO's staff based on the form designed by the Child Survival PVOs support office at the Johns Hopkins University. WVI consultants also participated in each of the interventions and in the training and implementation of the methodology.

The first two questions ask for the mother and child to be interviewed; questions 3 through 6 ask for information about the mother's activities and who takes care of the child while the mother works outside of the household; questions 7 through 11 deal with breastfeeding and weaning practices; questions 12 and 13 are about the child's growth monitoring card; questions 14 through 23 ask the mother what she did the last time the child had diarrhea and what the proper management of diarrhea is; questions 24 through 28 ask about practices and knowledge on symptoms compatible with acute respiratory illnesses; questions 29 through 34 deal with the mother's knowledge on and the current status of her child-under-two's immunization scheme as well as her own; questions 35 through 38 inquire about ante-natal control and delivery, questions 39 and 40 ask about dengue fever and last, questions 41 through 48 deal with family planning.

The questionnaire was originally written in Spanish and sent to WVRD and ORALYC. It was subsequently translated into English and included in the annexes.

B. Sample size.

A cluster sample size is a random sample where the sample unit is a collection or cluster of elements⁴. In this study, we chose to do our WV-Honduras Child Survival survey by a cluster sampling method.

⁴ Scheaffer y Menden hall. Elementos de Muestreo. México, 1986

The sample size calculation for this study considers multiple child survival interventions. Accordingly, the sample size was estimated based on the intervention that requires the largest sample size. The formula that was used was the following:

$$n = z^2 pq/d^2$$

Where **n** = sample size; **z** = 95% confidence limit = 1.96; **p** = prevalence or coverage rate; **q** = 1 - p; and **d** = desired precision, usually 5% to 10%

"p" was defined as the study intervention that requires the highest sample size. Considering the desired precision (5% to 10%), the following populations were required:

	Value p	
d	0.20	0.25
.05	246	288
.06	170	200

Substituting in the formula: $n = z^2 pq/d^2$

$$n = 1.96^2 (.2 \times .8/.05)^2$$

$$n = 246$$

"d", gives the desired precision and depends on the purpose of the study. If the objective is to find or evaluate rates for epidemiological studies with differences between 5% to 10%, d would give us the precision we need. For the World Vision Child Survival Project, prevalence for diarrhea was considered to be at 20% (Household Survey Manual: Diarrhoea Case Management; Morbidity and Mortality WHO, Geneva, 1989).

Confidence intervals were calculated using the following formula:

$$95\% \text{ CI} = p \pm z (pq/n)$$

Where **p** = population proportion; and **z** = a constant value

according to a normal statistical distribution.

C. Selection of the target population

We decided to take a sample from the population of women with children under 24 months of age living in the impact area of the WV Child Survival project in Colonia San Miguel, Tegucigalpa.

The WV team prepared a list of all the communities (sectors) in the project area with their population size. Once with the list of communities, we proceeded with the selection of 30 clusters/communities following the technique described in a WHO manual (Household Survey Manual: Diarrhoea Case Management, Morbidity and Mortality. WHO, Geneva, 1989).

Six teams of two interviewers and one supervisor were chosen. Each team interviewed 20 and 10 mothers respectively in the selected sectors and communities making a total of 30 sectors and 300 mothers of children less than 2 years old.

The blocks to be surveyed were chosen through a raffle in each neighborhood. Numbers representing each block were placed in a jackpot and then drawn to select the blocks to be surveyed in that neighborhood.

To select the first household to survey, numbers representing the households in a block were put in a jackpot and then one of them was drawn randomly and identified as the first household where the survey would start. The next step was to select by a lottery the direction to follow for the rest of the households. Once that was done, the closest household to the first was identified and the survey was continued until completing 10 questionnaires.

D. Training of Interviewers and Supervisors

The training for the interviewers and the supervisors was done in 4 consecutive days. WV had chosen 12 interviewers from the CHVs and staff from the CESAMO San Miguel.

The first day involved discussions about the time devoted to the survey and the personal involvement of the field staff and the other participants. Both the team and the program managers asked for a full review of the study methodology and the

logic for each of the questions so it would be understood completely. Modifications to the original questionnaire were introduced as well as the introduction of language modals particular for the area.

The second day was spent in the training of the interviewers and supervisors on the study methodology, revision of the forms and on interview techniques.

On the third day the training of the core team, interviewers and supervisors, was continued with the same topics as the day before.

The third and fourth day were spent training the interviewers and the supervisors on how to fill out the questionnaire. This kind of studies must always consider that questions have to be asked in the same way to really detect the knowledge and practices of the mothers. One of the problems to consider is the differences in the education level of the interviewers and their number (12 in this case), since there may be a bias given by them. Accordingly, we emphasized the need for uniformity during the training.

On the fourth day we proceeded with test interviews in areas close to the study area. Then we practiced on the manual tabulation of the data with the supervisors and the core team.

E. Interviews

Interviews were conducted as follows: La Esperanza, Brisas del Valle, La Era, La San Miguel, La Trinidad, La 30 de Noviembre, were interviewed on Monday, August 28; and La Izaguirre, La Sosa y la 28 de Marzo, on August 29.

On Wednesday 30 of August the interviews were conducted in La Travesía, 13 de Julio y Estados Unidos.

Every interview day was preceded by an orientation and recommendations to the community to be interviewed. Interviewers and supervisors were highly motivated, which accounted for the good coverage during the programmed days. Additionally, the field team carried on without difficulties in the project area.

The core team made continuous visits to the study sites to provide support to the teams and supervise the interviews.

F. Determining the Data Analysis Methodology

As questionnaires were brought to WV headquarters in San Miguel a data entry clerk introduced the information to a computer using the software EPI/INFO 6.0; this required 4 full days of work. This is a special software designed by CDC to conduct research studies, it is inexpensive, easy to use and provides a data analysis component adequate for this kind of study whose directions are easy to follow even for people with little experience with computers.

One section of the training of the personnel at WV was to tabulate the data and write the conclusions for the study right after finishing it. One of the purposes of the study was to provide the necessary tools for the timely decision making regarding the program developing.

For the first draft we saw frequency distributions for each of the questions. In some instances we did cross tables considering the children's age using EPI-INFO, in order to obtain second order indicators.

Once the frequency distribution and cross tables were finished, a few more tables were printed and included in the final report.

III. RESULTS

1. Mother's name and age

We found that 4% of all interviewed mothers are younger than 18 years (11/300) and that 8% are older than 35 years (24/300). Mean age was found to be 25.4 years. (Table No. 1)

2. Child's age

60.3% (181/300) of the children were in the 0-11 months range; 39.7% (119/300) of them lie between 11 and 23 months (Table No. 2).

MOTHER'S EDUCATION/OCUPATION

3. Out of 300 surveyed mothers, 91% (273) reported being able to read and 9% (27) said they could not read. (Table No. 3).
4. When asked whether she had an income generating activity, 75.2 % of the mothers reported none; only 24.8% of them worked, and out of these 6% worked doing household chores. (Table No. 4).
5. 58.4% of the mothers said they took care of their children themselves. 25% said it was their relatives. (Table No. 5).
6. 91.7% of the surveyed mothers reported respiratory infections as the most common in their children, followed by diarrheal disease with 2.3% (Table No. 6).

BREASTFEEDING/NUTRITION

7. Out of the 300 surveyed mothers 71.3% referred breastfeeding at the time of the interview. (Table No.7).

- 7.1. Out of 105 children under 6 months, 21.9% (23/300) were on exclusive breastfeeding according to their mothers.
8. Out of the 86 mothers who were not breastfeeding at the time of the interview 87.2% reported having done so at least once. 12.7% said they had not ever done it. (Table No. 8).
9. 63.7% out of 289 surveyed mothers reported having breastfed their children within the first hour of the delivery; 14.5% reported doing so within the first eight hours; and 20.8% after the first eight hours. In summary 78.2% of the mothers breastfed their children within the first eight hours after delivery. (Table No. 9).
10. Concerning the feeding practices of children 0 to 6 months, surveyed mothers reported the following:
- In the agegroup under 4 months, 59.2% had introduced water and teas, 47.4% powdered milk, 14.5% corn atole, 14.5% fruits, 14.5% carrots and squash, 6.6% beans; and finally, 13.2% eggs and cheese. (Table No. 10).
- In the agegroup from 4 to 6 months, 84.2% had introduced water and teas to their feeding habits, 55.3% had introduced powdered milk, 65.8% had given corn atole, 68.4% fruits, 47.4% carrots and squash, 7.9% green vegetables, 26.3% meat and fish, 21.1% beans, and 52.6% eggs and cheese. (Table No. 10).
- At the same time, 65.8% of children in the previously mentioned agegroup were eating sweets and sugar, and 44.7% vegetable oil and lard (Table No. 10).
11. Out of 300 surveyed mothers regarding the question of what they would do to improve the production of breast milk, 76.6% fell in the category of "other". 54.8% of these mentioned fluids and 12.7% mentioned eating better as ways to improve milk production. Only 13.7% mentioned frequent breastfeeding as a means of producing more milk. (Table No. 11).

GROWTH MONITORING

12. 53% of the 300 interviewed mothers referred having the growth control card for their children. 38% did not have it. (Table No. 12).
13. Regarding the weight registration for children less than 4 months of age on the growth control card 79.9% of those with a card had it registered, and 20.1% did not. (Table No. 13).

DIARRHEAL DISEASES

14. According to the surveyed mothers 78.7% of the children under 24 months had not had a diarrhea episode in the last two weeks. Only 21.3% had presented with an episode in the same period. (Table No. 14).
15. 53.1% of the mothers referred having breastfed more or the same when their children had diarrhea. 46.9% did not breastfeed. (Table No. 15).
16. 67.2% of the mothers reported that during their child's diarrheic episode they gave him either the same or higher amounts of fluids than usual. 32.8% did not provide more fluids or gave them less amounts than usual. (Table No. 16).
17. 46.9% of the mothers reported that they gave soft foods in greater or equal amounts during the diarrheic episodes, and 37.5% stopped feeds or gave the child a smaller amount. 15.6% only breastfed. (Table No. 17).
18. 49.3% of the mothers reported treating their children's diarrhea with drugs. Only 20.8% referred using oral rehydration salts. (Table No. 18).
19. 54.7% of the mothers referred that they did not ask for advice when their children had diarrhea. (Table No. 19).
20. 43.7% of the mothers who did ask for advice when their child had diarrhea asked the health personnel, hospitals, health centers and private clinics. Only 18.7% asked a health volunteer. Also, it is worth mentioning that 34.5% of

the mothers ask advice from relatives and friends. (Table No. 20).

21. 6.9% of the mothers reported they did not know the signs of severity when their child had diarrhea.. 30.4% of the mothers recognize dehydration as a sign of severity. (Table No. 21).
22. 18.5% of the mothers reported that when their child had diarrhea they took him/her to the health center. 27.6% of the mothers referred that they know how to provide oral rehydration salts. (Table No. 22).
23. 13.5% of the mothers said they did not know what to do when their children were recovering from a diarrhea episode; and 56.9% mentioned positive practices such as feeding them more frequently and giving foods with calories. (Table No. 23).

ACUTE RESPIRATORY INFECTIONS

24. 60.7% of the mothers refer that their child has been coughing or with chest discomfort during the past two weeks. (Table No. 24).
25. 55.5% of the mothers refer that their child has had rapid or tiring breathing. (Table No. 25).
26. Most of the mothers, 82.2%, refer that they look for help when their child has a chest illness. (Table No. 26).
27. 78.3% of the mothers looked for advice or help at the hospitals, health center, health workers and private clinics when their children had a chest problem.. 14.6% looked for help with relatives and only 3.9% ever looked for a health volunteer. (Table No. 27).
28. 82.3% of the mothers recognize signs of severity when their children had a chest problem.. (Table No. 28).

IMMUNIZATION

29. 98.3% of the children had been immunized at least once, versus 1.7% who had never been immunized. (Table No. 29).
30. 50.7% of the mothers reported that the measles vaccine should be applied when the child is 9 months old. On the other hand, 49.3% of the mothers sis not know when to apply the measles vaccine. (Table No. 30).
31. 36% of the mothers replied that a mother should get the tetaus vaccine in order to protect both the mother and the child; 12.7% replied that it was to protect just the mother and 29.7% said it was to protect just the child. In summary 78.3% of the mothers fully or partially know the reason to apply the vaccine. (Table No. 31)
32. 80.7% of the mothers reported that a pregnant woman should receive two or more shots of TT, 19.3% said it should be one, or did not know. (Table No. 32)
33. 90.7% of the mothers reported having the mother vaccination card. 9.3% said they did not have it. (Table No. 33).
34. 90% of the children between 12 and 23 months of age had their third dose of polio vaccine; 80.3% of the same group had the third dose of DPT and 88.3% had a dose of measles vaccine. 91.7% of the children aged 12 to 23 monts had a dose of BCG.. 85.8% of all the children between 12 and 23 months of age had a complete vaccination squeme. (Table No. 34a, 34b, 34c, 34d y 34e).

MATERNAL HEALTH

35. Regarding the ante-natal control card 49.3% of the women interviewed reported having it, and 50.7% said they did not have it. (Table No. 35).
36. Out of 148 mothers who showed their ante-natal control card, 2.7% had at least one registered visit, 95.9% had two or more visits and 1.4% did not have any visit. (Table No. 36).
37. 67.3% of the mothers presented their vaccination card against tetanus, 32.7%

did not present it. (Table No. 37).

38. Out of 202 mothers who showed their vaccination card 95% had two or more doses of TT, 4.5% had only one and 0.5% did not have any dose (Table No. 38).

DENGUE FEVER PREVENTION

39. 88.3% of the interviewed said they knew about dengue fever. (Table No. 39).
40. Out of 265 mothers who know what dengue fever is 64.15% mentioned two or more prevention measures.

FAMILY PLANNING AND PREGNANCY SPACING

41. Out of the total of interviewed mothers 94% were not pregnant, 5% were and 1% did not know. (Table No. 41).
42. Out of the 285 mothers who were not pregnant, 85.3% said they did not want another child in the next two years; and 5.2% said they did not know at this moment whether they wanted a child or not in the next 2 years. Only 9.5% said they wanted another child. (Table No. 42).
43. Out of 258 interviewed mothers who did not know or did not want another child in the next two years, 49.2% are using a modern family planning method. However 50.8% are not. (Table No. 43).
44. Out of the total of mothers who referred using a family planning method, 31.5% use the intra-uterine device (IUD), 26.2% have been surgically sterilized, 26.2% take the pill, 13.4% use condoms, 1.6% use a diafragm. (Table No. 44).
45. Out of the total interviewed women 92.3% responded that one should go to

ante-natal control during the first trimester, 3.7% said that half through the pregnancy, 1.3% said that in the last trimester, and 2.7% did not know. (Table No. 45).

46. Out of 300 interviewed mothers 90.3% said that they had visited either a health center, a private clinic or a hospital during their pregnancy; 9.7% did not visit any health facility. (Table No. 46).
47. Out of the 271 interviewed mothers 45% had attended an ante-natal control at CESAMO San Miguel, 16.7% had attended other health centers, 19.8% had gone to a private clinic and 18.5% had gone to the Social Security Hospital. (Table No. 47).
48. 93.3% of the mothers said that a health worker had cut their child's umbilical cord at the time of delivery, 5% said it had been a trained empirical midwife, 1% did not know; and in 0.7% of the cases it had been a family member. (Table No. 48).

ANNEX No. 1

CONSENT FORM TO BE READ TO THE MOTHER

CESAMO SAN MIGUEL -- WORLD VISION

My name is _____, and I represent CESAMO San Miguel. I would like to ask you some questions about your child's health so that we health workers know better the health status of our community. Some of these questions are about what you did when your child was sick. Some others are to find out what you know about the health problems that affect children. We will ask you this so that we know what to teach mothers in order to improve the children's health in the community.

These questions are directed to mothers with children under 2 years of age. You have been selected randomly amongst all the mothers living in the project's area and who have a child under 2 years.

The information you provide us with is strictly confidential. The reports do not mention people's names and they will only be used by the health worker in the planning of health programs. The interview will be about 20 minutes. The questionnaire is voluntary and you are free not to answer or decline participation. If you do not participate, it will not affect the services you receive at the health center; if you do participate you may refuse to answer any question that bothers you or end the interview whenever you desire.

¿May I then ask you the questions?

ANNEX No. 2

IDNUM: _____

WORLD VISION HONDURAS

QUESTIONNAIRE ON KNOWLEDGE AND PRACTICES OF CHILD
SURVIVAL, CESAMO SAN MIGUEL
(VERSION VI)

The following questions are for mothers of children under 2 years of age (24 months).

Date of the interview: __/__/95 Re-interview __/__/95 (day/month)
Interviewer name: _____
Supervisor _____
Address _____

1. Mother's name and age

Name _____ Age (years) _____

2. Name and age of child under 2 years

Name _____

Date of birth __/__/__
(dd/mm/yy)

Mother's education/occupation

Let us know about your education and occupations.

3. How many grades did you advance in school?
 1. None but reads
 2. None and does not read
 3. Complete primary and reads
 4. Complete primary and does not read
 5. Secondary education or higher

4. Do you work on any activity where you earn money? **(You may mark more than one response)**
 1. No, none
 2. Selling vegetables or fruits
 3. Selling food or tortillas
 4. As a maid/washing clothes, other services
 5. Store/outlet/salesperson/used clothing
 6. Employed worker
 7. Others (specify) _____

5. Who takes care of (name of the child) while you work or you are away from home? **(You may mark more than one response)**
 1. The child is/goes with the mother
 2. With husband/partner
 3. Older siblings
 4. Relatives
 5. Neighbors/friends
 6. The maid
 7. Day care
 8. Leaves the child alone

6. What is the most common illness in your home?

1. Respiratory illnesses
2. Fever
3. Seizures
4. Vomits/diarrhea
5. Female (ob-gyn)
6. Rheumatoid (joint aches)
7. Others (specify) _____

Breastfeeding/Nutrition

7. Are you breastfeeding (name of the child)?

1. Yes -----> **GO TO 9**
2. No

8. Did you ever breastfeed (name of the child)?

1. Yes
2. No -----> **GO TO 10**

9. After his/her birth, when did you breastfeed (name of the child) for the first time?

1. During the first hour after delivery
2. During the first 8 hours after delivery
3. More than 8 hours after delivery
4. Does not remember

10. a. Are you giving water (anise or camomile tea) to (name of the child)?

1. Yes
2. No
3. Does not know

- b. Are you giving powdered, liquid or cow milk to (name of the child)?
1. Yes
 2. No
 3. Does not know
- c. Are you giving soft foods such as atole or purees to (name of the child)?
1. Yes
 2. No
 3. Does not know
- d. Are you giving fruits to (name of the child)?
1. Yes
 2. No
 3. Does not know
- e. Are you giving carrots, squash, mangoes, beet or papaya to (name of the child)?
1. Yes
 2. No
 3. Does not know
- f. Are you giving green vegetables such as spinach, or mustard, carrots and beet leaves to (name of the child)?
1. Yes
 2. No
 3. Does not know
- g. Are you giving meat or fish to (name of the child)?
1. Yes
 2. No
 3. Does not know

- h. Are you giving beans to (name of the child)?
1. Yes
 2. No
 3. Does not know
- i. Are you giving eggs or cheese to (name of the child)?
1. Yes
 2. No
 3. Does not know
- j. Do you put sugar or sweetener to (name of the child)'s name?
1. Yes
 2. No
 3. Does not know
- k. Do you prepare (name of the child)'s food with vegetable oil or dard?
1. Yes
 2. No
 3. Does not know
11. What can a mother do during the first six months in order to produce more breast milk? **(YOU MAY MARK MORE THAN ONE RESPONSE)**
1. Does not know
 2. Breastfeed right after the delivery (without discarding the colostrum)
 3. Take care of the breasts and nipples
 4. Breastfeed frequently to stimulate milk production
 5. Breastfeed exclusively during the first six months
 6. Avoiding the bottle

7. Starting breastfeeding all over again (in case she had abandoned it)
8. Others (specify) _____

Growth Monitoring

12. Does (name of the child) have a card to control his weight?

1. Yes (Ask her to show it to you)
2. Lost the card -----> **GO TO 14**
3. No, never had -----> **GO TO 14**

13. Look at the child's card and register the following information: Has the child been weighed in the past 4 months?

1. Yes
2. No

Diarrheic Diseases

14. Has (name of the child) had diarrhea during the past two weeks?

1. Yes
2. No -----> **GO TO 21**
3. Does not know -----> **GO TO 21**

15. During (name of the child)'s diarrhea, did you breastfeed him/her?
----> **READ THE OPTIONS TO THE MOTHER**

1. more
2. the same
3. less

4. stopped breastfeeding
5. had already weaned him/her

16. During (name of the child)'s diarrhea, did you give him/her other fluids (besides breastfeeding)? -----> **READ THE OPTIONS TO THE MOTHER**

1. more
2. the same
3. less
4. did not give him/her any fluids
5. only breastfeeds

17. During (name of the child)'s diarrhea, did you give him/her soft foods or purees?

-----> **READ THE OPTIONS TO THE MOTHER**

1. more
2. the same
3. less
4. did not give him/her any foods
5. only breastfeeds

18. When (name of the child) had diarrhea, what kind of treatment did you give him/her? (if you gave him/her anything)

1. Nothing at all
2. Oral rehydration salts (Litrosol)
3. Water and salt solution (home made)
4. Rice water
5. Any fluid
6. Anti-diarrheal drugs or antibiotics
7. Other (specify)_____

19. When (name of the child) had diarrhea, did you ask for advice or help?

1. Yes
2. No

-----> **GO TO 21**

20. Whom did you ask for advice or help regarding (name of the child)'s diarrhea? **(May mark more than one answer).**

1. General Hospital/Social Security Hospital
2. Health Center/Health facility
3. Private physician/clinic
4. Pharmacy
5. Health volunteer or Litrosol provider
6. Healer
7. Midwife
8. Relatives and friends
9. Other (specify) _____

21. What severity signs would make you go look for help if (name of the child) had diarrhea? **(You may mark more than one response)**

1. Does not know
2. Vomit
3. Fever
4. Dry mouth, sunk eyeballs or fontanel, little urine (dehydration)
5. Prolonged diarrhea
6. Blood in stool
7. Loss of appetite
8. Weak and not eating
9. Other (specify) _____

22. What can a mother do when his/her child has diarrhea? **(You may mark more than one response)**

1. Does not know
2. Start fluids as soon as possible
3. Give the child more fluids than usual
4. Frequent feedings in small amounts
5. Make and give ORS adequately
6. Take the child to a health center
7. Feed the child more so he/she will not lose weight
8. Stop giving fluids

9. Stop feedings
 10. Other (specify) _____
23. What does a mother have to do once the child has recovered from a diarrhea episode? **(You may mark more than one response).**
1. Does not know
 2. Frequent feedings in small amounts
 3. Give the child more foods than usual
 4. Give foods with high caloric value
 5. Other (specify) _____

Acute Respiratory Infections

24. Has (name of the child) been ill with cough or chest discomfort in the past two weeks?
1. Yes
 2. No -----> **GO TO 28**
25. Has (name of the child) had rapid and/or tiring breathing (disnea)?
1. Yes
 2. No -----> **GO TO 28**
 3. Does not know -----> **GO TO 28**
26. Did you look for help for (name of the child) when his/her chest was not feeling well?
1. Yes
 2. No -----> **GO TO 28**

27. Who gave you help or advice when (name of the child)'s chest was not fine? (You may mark more than one answer).

1. General Hospital/Social Security Hospital
2. Health Center/Health facility
3. Private physician/clinic
4. Pharmacy
5. Health volunteer or Litrosol provider
6. Healer
7. Midwife
8. Relatives and friends
9. Other (specify) _____

28. What are the severity signs that would make you go look for help if (name of the child)'s chest was not fine?
(You may mark more than one response)

1. Does not know
2. Rapid and agitated breathing
3. Traction in between the ribs
4. Loss of appetite
5. Fever
6. Cough
7. Other (specify) _____

Immunizations

29. Has (name of the child) ever been vaccinated?

1. Yes
2. No
3. Does not know

30. What age was (name of the child) when he/she was vaccinated for measles?

1. Specify the month

2. Does not know
31. What is the main reason for a woman to be vaccinated against tetanus/
 1. To protect the mother and the child against tetanus
 2. To protect only the woman against tetanus
 3. To protect only the child against tetanus
 4. Others or does not know
32. How many tetanus vaccine doses should a pregnant woman receive?
 1. One
 2. Two
 3. More than two
 4. None
 5. Does not know
33. Do you have (name of the child)'s immunization card?
 1. Yes (Ask her to show it to you)
 2. She lost it ---> **GO TO 35**
 3. No, never had one ---> **GO TO 35**

34. Look at the immunization card and register the immunization dates in the corresponding spaces.

	FIRST	SECOND	THIRD
OPV	__/__/__	__/__/__	__/__/__
DPT	__/__/__	__/__/__	__/__/__
MEASLES	__/__/__		
BCG	__/__/__		

Maternal Health

35. Do you have your ante-natal control card?

- | | | |
|----|-------------------|-----------------------------|
| 1. | Yes | (Ask her to show it to you) |
| 2. | She lost it | ---> GO TO 37 |
| 3. | No, never had one | ---> GO TO 37 |

36. Look at the ante-natal control card and register how many visits she had:

- | | |
|----|-------------|
| 1. | One |
| 2. | Two or more |
| 3. | None |

37. Do you have the TT vaccination card?

- | | | |
|----|-------------------|-----------------------------|
| 1. | Yes | (Ask her to show it to you) |
| 2. | She lost it | ---> GO TO 39 |
| 3. | No, never had one | ---> GO TO 39 |

38. Look at the card in the TT space and register the number of doses received:

- | | |
|----|-------------|
| 1. | One |
| 2. | Two or more |
| 3. | None |

Dengue Fever

39. Do you know what dengue fever is?
1. Yes
 2. No -----> **GO TO 41**
40. What does one do to control the Dengue fever vector?
(You may mark more than one response)
1. Wash the water collection basin
 2. Eliminate containers
 3. Cover containers
 4. Does not know
 5. Others (specify) _____

Family Planning and Pregnancy Spacing

41. Are you pregnant now?
1. Yes -----> **GO TO 45**
 2. No
 3. Does not know
42. Would you want another child in the next two years?
1. Yes -----> **GO TO 45**
 2. No
 3. Does not know
43. Are you currently using a method to avoid becoming pregnant or delay the next pregnancy?
1. Yes

2. No

-----> **GO TO 45**

44. What is the main family planning method you, or your husband, are using to avoid you getting pregnant?

1. Tubal ligation/Vasectomy
2. Injections
3. Contraceptive pills
4. Intra-uterine device
5. Diaphragm
6. Condoms
7. Foams or gel
8. Exclusive breastfeeding
9. Method of Rhythm
10. Abstinence
11. Coitus interruptus
13. Others (specify) _____

45. How soon should a woman go to a doctor, nurse or midwife when she is pregnant?

1. First trimester: months 1-3
2. Half through pregnancy: months 4-6
3. Last trimester: months 7-9
4. Does not need to go
5. Does not know

46. When you were pregnant with (name of the child), did you visit any health center (clinic or hospital) for your ante-natal control?

1. Yes
2. No

-----> **GO TO 48**

47. Where did you have your ante-natal controls? (specify health center or hospital)

A. _____

48. When (name of the child) was born, who cut and tied his/her umbilical cord?

1. Herself
2. A family member
3. Midwife
4. Health worker (physician/nurse)
5. Does not know
6. Other (specify) _____

ANNEX 3
TRAINING PROGRAM

August 22

- I. Presentation (7:30 - 8:00)
 - a) Introduction by couples
 - 1. Name
 - 2. Where do you come from?
 - 3. Activity/occupation
 - 4. Pin the badge

- II. Agenda review (8:00 - 8:30)
 - a) Present and discuss the agenda for everyday.

 - b) Survey Timeline presentation.
 - 1. Training
 - 2. Survey
 - 3. Tabulation and Analysis
 - 4. Report

- III. Objectives of a KAP survey (8:30 - 9:00)
 - a) Define the goals and objectives of the survey
 - 1. Why are we conducting this survey?
 - 2. What to we want to obtain through it?

- IV. RECESS (9:00 - 9:15)

- V. Methodology (9:15 - 12:00)
 - a. Describe the KAP survey.

SB

- b. Explain the procedure to estimate the sample size and its rationale.
- c. Discuss the household selection according to the cluster sampling technique.

VI. LUNCH (12:00 - 1:30)

VII. Questionnaire review (1:30 - 3:30)

- a. Go over the questionnaire step by step.
- b. Explain each question's meaning
 - 1. Why are we asking the question?
 - 2. What do we want to know?
- c. We will not discuss how to make the questions.
- d. Coding the questionnaire.
 - 1. Review all questions again and show how they should be registered.
 - 2. Questions with multiple answers should be understood by the interviewers.

TRAINING PROGRAM

August 23

- I. Review of previous day topics (7:30 - 8:00)
 - a. Objectives
 - b. Summary of the methodology
 - c. Important point for the questionnaire review
- II. Interview Techniques (8:00 - 9:00)
 - a. Review and discuss questions
- III: RECESS (9:00 - 9:15)
- IV. Interview technique (9:15 - 12:00)
 - a) Review the language and format to present the questions.
- V. LUNCH (12:00 - 1:30)
- VI. Role play (1:30 - 2:45)
 - a. A supervisor plays the role of a local mother.
 - 1. Show how to adhere to the question's meaning without biasing the response.
 - 2. Go over two interpretations with the supervisors.
 - a. Show how to make a good interview.
 - b. Show how to make a bad interview.
 - 3. Team involvement:
 - a. Everyone will have the chance to play either a mother and the interviewer.
- VII. RECESS (2:45 - 3:00)
- VIII. Role plays discussion

- a. A general discussion will be conducted where specific aspects of the scenarios will be discussed.

TRAINING PROGRAM

August 24

- I. Summary of the previous day. (7:30 - 8:00)
- II. Roles were assigned. (8:30 - 9:30)
 1. Core Team's role
 2. Supervisors role
 3. Interviewers role.
- III. RECESS (9:30 - 9:45)
- IV. Role play (9:45 - 12:00)
 1. Interviews free of mistakes (3)
 2. Discussion
- V. LUNCH
- VI. Tabulation (1:30 - 3:00)
- VII. RECESS (3:00 - 3:15)
- VIII. Preparing for the practice
 - a. Logistics
 - b. Locality
 - c. Supervisors
 - d. Interviewers

ANNEX No. 4

#	NAME OF THE NEIGHBORHOOD	POPULATION	CUMULATIVE FREQUENCY	CLUSTER NUMBER
1	Esperanza	4054	4054	2
2	Era	3428	7482	3
3	Brisas del Valle	1286	8768	1
4	30 de Noviembre	4022	12790	2
5	San Miguel	7678	20488	6
6	28 de Marzo	3634	24122	2
7	La Trinidad	2755	26877	2
8	La Travesía	5847	32724	4
9	La Izaguirre	3066	35790	2
10	13 de Julio	1504	37294	1
11	Estados Unidos	1973	39267	1
12	La Sosa	4901	44168	4
	T O T A L	44168		30

$$\text{INTERVAL} = \frac{44168}{30} = 1472.$$

$$\text{RANDOM NUMBER} = \underline{\quad 1314 \quad}$$

ANNEX No. 5

SELECTION OF THE PLACE TO BEGIN THE SURVEY

1. Place yourself at the most centric place of the block or cluster (it may be a church, school, outlet or any other).
2. Randomly, select the "address of the household" where you are going to start. You can do that by rotating a bottle on the floor and begin in the direction where it stops, or you may flip a coin.
3. Randomly select the "first household" to begin. You can do this by counting the number of households on the street of the selected direction and then choose one of them randomly.

Example: If there are 10 households in the street, select a random number from 1 to 10 and if it is nine, then start with the ninth house.

4. Once you have selected the first household, the second will be that which is closer to the first one and so on and so forth.

ANNEX No. 6

TABLE 1

MOTHER'S AGE

EDAD MAD	Freq	Percent	Cum.
15	4	1.3%	1.3%
16	1	0.3%	1.7%
17	7	2.3%	4.0%
18	20	6.7%	10.7%
19	23	7.7%	18.3%
20	21	7.0%	25.3%
21	25	8.3%	33.7%
22	15	5.0%	38.7%
23	28	9.3%	48.0%
24	15	5.0%	53.0%
25	19	6.3%	59.3%
26	12	4.0%	63.3%
27	14	4.7%	68.0%
28	17	5.7%	73.7%
29	13	4.3%	78.0%
30	6	2.0%	80.0%
31	4	1.3%	81.3%
32	12	4.0%	85.3%
33	4	1.3%	86.7%
34	5	1.7%	88.3%
35	11	3.7%	92.0%
36	3	1.0%	93.0%
37	4	1.3%	94.3%
38	6	2.0%	96.3%
39	6	2.0%	98.3%
40	3	1.0%	99.3%
46	1	0.3%	99.7%
50	1	0.3%	100.0%
Total	300	100.0%	

TABLE 2

CHILD'S AGE IN MONTHS

EDADNINO	Freq	Percent	Cum.
0	15	5.0%	5.0%
1	20	6.7%	11.7%
2	26	8.7%	20.3%
3	15	5.0%	25.3%
4	11	3.7%	29.0%
5	18	6.0%	35.0%
6	9	3.0%	38.0%
7	12	4.0%	42.0%
8	9	3.0%	45.0%
9	18	6.0%	51.0%
10	14	4.7%	55.7%
11	14	4.7%	60.3%
12	14	4.7%	65.0%
13	10	3.3%	68.3%
14	10	3.3%	71.7%
15	7	2.3%	74.0%
16	10	3.3%	77.3%
17	12	4.0%	81.3%
18	9	3.0%	84.3%
19	10	3.3%	87.7%
20	7	2.3%	90.0%
21	4	1.3%	91.3%
22	11	3.7%	95.0%
23	15	5.0%	100.0%
Total	300	100.0%	

TABLE 3

HOW MANY GRADES DID YOU ADVANCE IN SCHOOL?

N3HASTAQUE		Freq	Percent	Cum.
-----+-----				
1	NONE & READS	9	3.0%	3.0%
2	NONE & DOESN'T	7	2.3%	5.3%
3	PRIM & READS	158	52.7%	58.0%
4	PRIM & DOESN'T	20	6.7%	64.7%
5	SEC. OR MORE	106	35.3%	100.0%
-----+-----				
Total		300	100.0%	

TABLE 4

DO YOU WORK ON ANY ACTIVITY WHERE YOU EARN MONEY?

RECIBE DINERO?		Freq	Percent
-----+-----			
NONE	1	227	75.2%
SELLS FRUITS	2	1	0.3%
" FOOD	3	14	4.6%
AS MAID	4	18	6.0%
AT STORE	5	16	5.2%
EMPLOYED	6	18	6.0%
OTHER	7	8	2.7%
-----+-----			
Total		302	100%

TABLE 4a

OTHER INCOME		Freq	Percent
OTROS INGRESOS			
SEWING		1	12.5%
DRESS MAKING		1	12.5%
HAIR STYLIST		1	12.5%
ENTREPRENEUR		1	12.5%
HANDICRAFTS		1	12.5%
TAILORING		1	12.5%
DID NOT SPECIFY		2	25.0%
Total		8	100.0%

TABLE 5

WHO TAKES CARE OF THE CHILD WHILE YOU WORK OR ARE AWAY FROM HOME

FUERA DE CASA?		Freq	Percent
IS/GOES W-MOTHER	1	184	58.4%
HUSBAND/PARTNER	2	9	2.9%
OLDER SIBLINGS	3	28	8.9%
RELATIVES	4	79	25.0%
NEIGHBORS/Friends		8	2.5%
MAID	6	6	1.9%
DAY-CARE CENTER	7	1	0.4%
Total		315	100%

TABLE 6

WHAT IS THE MOST COMMON ILLNESS IN YOUR HOME?

IRA		Freq	Percent	Cum.
RESP. ILLNESS	1	275	91.7%	92.3%
		FEVER		
	2	3	1.0%	93.3%
VOMIT/DIARR.	4	7	2.3%	95.3%
RHEUMATISM	6	2	0.7%	96.0%
OTHERS	7	13	4.3%	100.0%
Total		300	100.0%	

TABLE 6a

OTHER ILLNESSES			
	Freq	Percent	Cum.
ALLERGIES	1	7.7%	7.7%
ASTHMA	1	7.7%	15.4%
CARDIAC (FEMALE)	1	7.7%	23.1%
CARDIAC (MALE)	1	7.7%	30.8%
HEADACHES	1	7.7%	38.5%
COLIC	1	7.7%	46.2%
DENGUE FEVER	1	7.7%	53.8%
NONE	6	46.2%	100.0%
Total 13 100.0%			

TABLE 7

ARE YOU BREASTFEEDING? ESTA DANDO DE MAMAR?			
	Freq	Percent	Cum.
YES	214	71.3%	71.3%
NO	86	28.7%	100.0%
Total 300 100.0%			

TABLE 8

DID YOU EVER BREASTFEED THE CHILD?
LE DIO DE MAMAR ALGUNA VEZ?

		Freq	Percent
YES 1		75	87.2%
NO 2		11	12.9%
Total		86	100.0%

TABLE 9

AFTER HIS/HER BIRTH, WHEN DID YOU BREASTFEED HIM/HER FOR THE
FIRST TIME?
DESPUES DEL NAC. CUANDO SE PEGO AL PECHO AL NIÑO?

		Freq	Percent
FIRST HOUR 1		184	63.7%
FIRST 8 HOURS 2		42	14.5%
MORE THAN 8 HR 3		60	20.8%
DOESN'T REMEMB 4		3	1.0%
Total		289	100.0%

TABLE 11

WHAT CAN A MOTHER DO DURING THE FIRST SIX MONTHS IN ORDER TO
PRODUCE MORE BREAST MILK?

	Freq	Percent
1	16	4.6%
2	5	1.4%
3	1	0.3%
4	48	13.7%
5	10	2.8%
6	1	0.3%
7	2	0.6%
8	268	76.6%
Total	351	100%

KEY:

1. DOES NOT KNOW
2. BREASTFEED RIGHT AFTER THE DELIVERY
3. TAKE CARE OF THE BREASTS AND NIPPLES
4. BREASTFEED FREQUENTLY TO STIMULATE MILK PRODUCTION
5. BREASTFEED EXCLUSIVELY DURING THE FIRST SIX MONTHS
6. AVOIDING THE BOTTLE
7. STARTING BREASTFEEDING ALL OVER AGAIN
8. OTHERS

TABLE 11a

OTHERS	Freq	Percent	Cum.
MORE FOOD	1	0.4%	0.4%
MORE FOODS	33	12.3%	12.7%
MORE FLUIDS	3	1.1%	13.8%
TAKE FLUIDS	1	0.4%	14.2%
TAKE FLUIDS, MORE FOODS	1	0.4%	14.6%
TAKE FLUIDS, MORE FOODS	1	0.4%	14.9%
TAKE FLUIDS	138	51.5%	66.4%
TAKE FLUIDS, MORE FOODS	2	0.7%	67.2%
TAKE FLUIDS AND VITAMINS	1	0.4%	67.5%
TAKE FLUIDS, MORE FOODS	1	0.4%	67.9%
TAKE FLUIDS, MORE FOODS	1	0.4%	68.3%
TAKE FLUIDS, MORE FOODS	1	0.4%	68.7%
TAKE FLUIDS, MORE FOODS	1	0.4%	69.0%
TAKE FLUIDS, MORE FOODS	1	0.4%	69.4%
TAKE FLUIDS, MORE FOODS	69	25.7%	95.1%
TAKE FLUIDS, MORE FOODS	9	3.4%	98.5%
TAKE FLUIDS	1	0.4%	98.9%
TAKE MORE FLUIDS	1	0.4%	99.3%
TAKE FLUIDS	1	0.4%	99.6%
TAKE FLUIDS	1	0.4%	100.0%
Total	268	100.0%	

TABLE 12

DO YOU HAVE YOUR CHILD'S WEIGHT CONTROL CARD?
 TIENE SU TARJETA DE CONTROL DE PESO?

	Freq	Percent	Cum.
YES	159	53.0%	53.0%
LOST	27	9.0%	62.0%
NO, NEVER	114	38.0%	100.0%
Total	300	100.0%	

TABLE 13

LOOK AT THE CARD AND REGISTER THE INFORMATION
MIRE LA TARJETA Y REGISTRE LA INFORMACION

	Freq	Percent	Cum.
YES1	127	79.9%	79.9%
NO 2	32	20.1%	100.0%
Total	159	100.0%	

TABLE 14

HAS THE CHILD HAD DIARRHEA IN THE PAST TWO WEEKS?
HA TENIDO DIARREA EN ULTIMAS 2 SEMANAS?

	Freq	Percent	Cum.
YES1	64	21.3%	21.3%
NO 2	236	78.7%	100.0%
Total	300	100.0%	

TABLE 15

DID YOU BREASTFEED HIM/HER DURING THE DIARRHEA EPISODE?
DURANTE LA DIARREA LE DIO DE MAMAR?

		Freq	Percent	Cum.
MORE	1	18	28.1%	28.1%
THE SAME	2	16	25.0%	53.1%
LESS	3	1	1.6%	54.7%
STOPPED BREASTFEED	4	4	6.3%	60.9%
ALREADY WEANED	5	25	39.1%	100.0%
Total		64	100.0%	

TABLE 16

DID YOU GIVE HIM/HER OTHER FLUIDS?
LE DIO OTROS LIQUIDOS?

		Freq	Percent	Cum.
MORE	1	27	42.2%	42.2%
THE SAME	2	16	25.0%	67.2%
LESS	3	1	1.6%	68.8%
ONLY FLUIDS	4	14	21.9%	90.6%
ONLY BREASTFED	5	6	9.4%	100.0%
Total		64	100.0%	

TABLE 17

DID YOU GIVE HIM/HER SOFT FOODS?
LE DIO ALIMENTOS BLANDOS?

		Freq	Percent	Cum.
MORE	1	11	17.2%	17.2%
THE SAME	2	19	29.7%	46.9%
LESS	3	10	15.6%	62.5%
DIDN'T GIVE	4	14	21.9%	84.4%
ONLY BREASTFED	5	10	15.6%	100.0%
Total		64	100.0%	

TABLE 18

WHAT TREATMENT DID YOU GIVE HIM/HER?
QUE TRATAMIENTO LE DIO?

		Freq	Percent
NOTHING	1	8	10.4%
ORS	2	16	20.8%
HOME MADE ORS	3	1	1.3%
RICE WATER	4	1	1.3%
ANY FLUID	5	9	11.7%
ANTIBIOTIC/ANTIDI	6	38	49.3%
OTHERS	7	4	5.2%
Total		77	100%

TABLE 18a

OTHER TREATMENT OTROS TRATAMIENTOS			
	Freq	Percent	Cum.
RICE WATER	1	25.0%	25.0%
CAMOMILE TEA	1	25.0%	50.0%
GIVE DRUGS	1	25.0%	75.0%
BREASTFEED	1	25.0%	100.0%
Total	4	100.0%	

TABLE 19

DID YOU ASK FOR ADVICE OR HELP? PIDIO CONSEJO O AYUDA?			
	Freq	Percent	Cum.
YES1	29	45.3%	45.3%
NO 2	35	54.7%	100.0%
Total	64	100.0%	

TABLE 20

WHO DID YOU GO FOR ADVICE OR HELP? A QUIEN LE PIDIO CONSEJO O AYUDA?			
		Freq	Percent
HOSPITALS	1	9	28.1%
HEALTH CENTER	2	3	9.4%
PRIVATE CLINIC	3	2	6.2%
HEALTH VOLUNTEE	5	6	18.7%
MIDWIFE	7	1	3.1%
RELATIVES/FRIENDS	8	11	34.5%
Total		32	100

TABLE 21

DO YOU RECOGNIZE SIGNS OF SEVERITY?
CONOCIMIENTO DE SEÑALES DE GRAVEDAD

		Freq	Percent
DSNOT KNOW	1	28	6.9%
VOMIT	2	58	14.5%
FEVER	3	58	14.5%
DEHYDRAT	4	122	30.4%
BLOODY STOOL	6	13	3.2%
NOT HUNGRY	7	44	11.0%
WEAKNESS	8	43	10.7%
OTHERS	9	35	8.8%
Total		401	100

TABLE 21a

OTHER SIGNS	Freq	Percent	Cum.
ESPEC21			
LOTS OF DIARRHEA	1	2.9%	2.9%
LOW WEIGHT	1	2.9%	5.7%
GO TO THE CESAMO	1	2.9%	8.6%
TIRED	1	2.9%	11.4%
UNDERNOURISHMENT	1	2.9%	14.3%
UNDERNOURISHED	1	2.9%	17.1%
LOTS OF DIARRHEA	6	17.1%	34.3%
LOTS OF DIARRHEA	1	2.9%	37.1%
DIARRHEA WITH MUCUS	2	5.7%	42.9%
DIARRHEA WITH BLOOD	1	2.9%	45.7%
FREQUENT DIARRHEA	1	2.9%	48.6%
LOTS OF DIARRHEA	1	2.9%	51.4%
CRAMPS	1	2.9%	54.3%
ABUNDANT STOOLS	1	2.9%	57.1%
FREQUENT STOOLS	2	5.7%	62.9%
VERY FREQUENT STOOLS	1	2.9%	65.7%
VERY FREQUENT STOOLS	1	2.9%	68.6%
HYPERACTIVE	1	2.9%	71.4%
IRRITATION	1	2.9%	74.3%
CRYING AND SAD	1	2.9%	77.1%
CRYING	3	8.6%	85.7%
WEIGHT LOSS	2	5.7%	91.4%
CRIES	1	2.9%	94.3%
SAD	2	5.7%	100.0%
Total		35	100.0%

75

TABLE 22

WHAT SHOULD A MOTHER DO WHEN HER CHILD HAS DIARRHEA?
QUE DEBE HACER UNA MADRE CUANDO SU NIÑO TIENE DIARREA?

		Freq	Percent
DSNOT KNOW	1	8	1.5%
FLUIDS	2	81	14.8%
MORE FLUIDS	3	95	17.4%
FOODS	4	27	4.9%
LITROSOL	5	151	27.6%
HEALTH CENTER	6	101	18.5%
MORE FOODS	7	20	3.7%
STOP FLUIDS	8	6	1.1%
STOP FOOD	9	5	0.9%
OTHER	10	53	9.6%
Total		547	100%

TABLE 22a

OTHER	Freq	Percent	Cum.
GIVE DRUGS	1	1.9%	1.9%
HYGIENE	4	7.5%	9.4%
LOOK FOR A DOCTOR	1	1.9%	11.3%
LOOK FOR MEDICINE	1	1.9%	13.2%
CONSULT PHYSICIAN	1	1.9%	15.1%
TAKE CARE OF CHILD	1	1.9%	17.0%
TAKE CARE OF HIM/HER	2	3.8%	20.8%
BREASTFEED	1	1.9%	22.6%
BREASTFEED	1	1.9%	24.5%
BREASTFEED	1	1.9%	26.4%
BREASTFEED MORE	1	1.9%	28.3%
GIVE DRUGS	1	1.9%	30.2%
GIVE DRUGS	1	1.9%	32.1%
GIVE DRUGS	1	1.9%	34.0%
GIVE DRUGS	1	1.9%	35.8%
GIVE DRUGS	2	3.8%	39.6%
BREASTFEED	1	1.9%	41.5%
BREASTFEED	1	1.9%	43.4%
GO TO THE CESAMO	1	1.9%	45.3%
FLUIDS	1	1.9%	47.2%
TAKE THE CHILD TO THE DOCTOR	3	5.7%	52.8%
BREASTFEED MORE	1	1.9%	54.7%
DRUGS	1	1.9%	56.6%
DRUGS	6	11.3%	67.9%
DRUGS	2	3.8%	71.7%
HOME MEDICINE	1	1.9%	73.6%
NATURAL MEDICINE	1	1.9%	75.5%
DRUGS	4	7.5%	83.0%
DO NOT EAT EARTH	1	1.9%	84.9%
STOP MILK	1	1.9%	86.8%
STOP POWDERED MILK	1	1.9%	88.7%
GIVE FLUIDS WITH VITAMINS	1	1.9%	90.6%
STOP MILK	1	1.9%	92.5%
VISIT THE DOCTOR	1	1.9%	94.3%
VISIT A CLINIC	1	1.9%	96.2%
VISIT THE HEALTH CENTER	1	1.9%	98.1%
VITAMINS	1	1.9%	100.0%
Total	53	100.0%	

TABLE 23

WHAT SHOULD A MOTHER DO WHEN THE CHILD IS RECOVERING?

		Freq	Percent
DSNOT KNOW	1	49	13.5%
FREQ FEEDINGS	2	96	26.4%
MORE FOOD	3	86	23.6%
CALORIC FOODS	4	25	6.9%
OTHER	5	108	29.6%
Total		364	100%

TABLE 23a

	Freq	Percent	Cum.
HYGIENE	1	0.9%	0.9%
BOILED WATER	1	0.9%	1.9%
BOILED WATER, CARE	1	0.9%	2.8%
SOFT FOODS	1	0.9%	3.7%
SOFT FOODS	1	0.9%	4.6%
HYGIENE	9	8.3%	13.0%
HYGIENE AND MORE FLUIDS	1	0.9%	13.9%
CONTINUE THERAPY	1	0.9%	14.8%
TAKE CARE OF HIM/HER	1	0.9%	15.7%
TAKE CARE OF HIM/HER	3	2.8%	18.5%
CARE	1	0.9%	19.4%
TAKE CARE OF HIM/HER	1	0.9%	20.4%
TAKE CARE OF HIM/HER	16	14.8%	35.2%
TAKE MORE CARE OF HIM/HER	1	0.9%	36.1%
TAKE CARE OF HIM/HER	1	0.9%	37.0%
GIVE BOILED WATER	1	0.9%	38.0%
GIVE FOODS	1	0.9%	38.9%
GIVE SOFT FOODS	1	0.9%	39.8%
GIVE FOODS	1	0.9%	40.7%
BREASTFEED	3	2.8%	43.5%
GIVE SAME AMOUNT OF FOOD	1	0.9%	44.4%
GIVE FLUIDS	14	13.0%	57.4%
GIVE LITROSOL	2	1.9%	59.3%
GIVE MORE MILK	1	0.9%	60.2%
GIVE DRUGS, BOILED WATER	1	0.9%	61.1%
GIVE DRUGS	1	0.9%	62.0%
BREASTFEED	2	1.9%	63.9%
GIVE SALTS	1	0.9%	64.8%
GIVE SALTS WITH VITAMINS	1	0.9%	65.7%
GIVE THERAPY	1	0.9%	66.7%
GIVE VITAMINS	1	0.9%	67.6%
GIVE FOODS	1	0.9%	68.5%
GIVE MILK	1	0.9%	69.4%
GIVE HIM/HER FLUIDS	2	1.9%	71.3%
GIVE MORE FLUIDS	1	0.9%	72.2%
CHECK THE WEIGHT	1	0.9%	73.1%
BOIL THE BOTTLES	1	0.9%	74.1%
FOLLOW MEDICAL ORDERS	1	0.9%	75.0%
FOLLOW MEDICAL ORDERS	1	0.9%	75.9%
FLUIDS	1	0.9%	76.9%
MORE FOODS, HYGIENE	1	0.9%	77.8%
MORE FLUIDS	3	2.8%	80.6%
DRUGS	1	0.9%	81.5%
DRUGS	2	1.9%	83.3%
DO NOT GIVE FOODS, GIVE DRUGS	1	0.9%	84.3%
STOP FOODS	1	0.9%	85.2%
SOUPS	1	0.9%	86.1%
BE CAREFUL WITH THE FOOD	1	0.9%	87.0%
FINISH DRUG THERAPY	1	0.9%	88.0%
TEAS, DRUGS	1	0.9%	88.9%
TAKE FLUIDS	1	0.9%	89.8%
VITAMINS	10	9.3%	99.1%
VITAMINS	1	0.9%	100.0%

Total	108	100.0%	

TABLE 24

HAS THE CHILD HAD COUGH OR CHEST DISCOMFORT?

HA ESTADO CON TOS O MAL DEL PECHO?

P24	Freq	Percent	Cum.
YES1	182	60.7%	60.7%
NO 2	118	39.3%	100.0%
Total	300	100.0%	

TABLE 25

HAS THE CHILD HAD RAPID OR TIRING BREATHING?

P25	Freq	Percent	Cum.
YES 1	101	55.5%	55.5%
NO 2	80	44.0%	99.5%
DSNOT KN3	1	0.5%	100.0%
Total	182	100.0%	

TABLE 26

DID YOU LOOK FOR HELP WHEN HIS/HER CHEST WAS NOT WELL?

BUSCO AYUDA CUANDO ESTABA MAL DEL PECHO?

	Freq	Percent	Cum.
YES1	83	82.2%	82.2%
NO 2	18	17.8%	100.0%
Total	101	100.0%	

TABLE 27

WHO GAVE YOU ADVICE OR HELP?
DE QUIEN RECIBIO CONSEJO O AYUDA?

		Freq	Percent
HOSPITAL	1	35	34.7%
HEALTH CENTER	2	24	23.8%
DOCTOR/CLINI	3	20	19.8%
PHARMACY	4	1	0.9%
VOLUNTEER	5	4	3.9%
RELATIVE/FRIE	8	15	14.6%
OTHER	9	2	2.3%
Total		101	100%

TABLE 27a

OTHER ADVICE
OTROS CONSEJOS

	Freq	Percent	Cum.
GIVE HIM/HER TEA	1	50.0%	50.0%
HER MOTHER	1	50.0%	100.0%
Total		2	100.0%

TABLE 28

WHAT ARE THE SEVERITY SIGNS IN THE CHEST?
CUALES SON LAS SEÑALES DE GRAVEDAD DEL PECHO?

		Freq	Percent
DSNOT KNOW	1	14	2.7%
RAPID BREATH	2	247	47.5%
TRACTION-RIBS	3	30	5.8%
LOSS APETITE	4	24	4.6%
FEVER	5	87	16.7%
COUGH	6	87	16.7%
OTHER	7	30	6.0%
Total		519	100%

TABLE 28a

OTHER SIGNS OF SEVERITY OF CHEST ILLNESS OTRAS SEÑALES DE GRAVEDAD DEL PECHO			
	Freq	Percent	Cum.
ASTHMA	2	6.7%	6.7%
LOOK FOR DOCTOR	1	3.3%	10.0%
TIRED	1	3.3%	13.3%
CIANOSIS	3	10.0%	23.3%
SEIZURES	1	3.3%	26.7%
WEAK	1	3.3%	30.0%
HOARSENESS	3	10.0%	40.0%
CHEST RALES	1	3.3%	43.3%
CHEST RALES	6	20.0%	63.3%
CRYING CHILD	1	3.3%	66.7%
RINORRHEA	1	3.3%	70.0%
IMPATIENT CHILD	1	3.3%	73.3%
CAN NOT SLEEP	1	3.3%	76.7%
RINORRHEA	2	6.7%	83.3%
RINORRHEA	1	3.3%	86.7%
ONLY CRIES	1	3.3%	90.0%
SAD	1	3.3%	93.3%
VOMIT	1	3.3%	96.7%
VOMIT AND DEHYDRATION	1	3.3%	100.0%
Total 30 100.0%			

TABLE 29

HAS YOUR CHILD EVER BEEN IMMUNIZED? HA SIDO VACUNADO ALGUNA VEZ?				
		Freq	Percent	Cum.
YES	1	295	98.3%	98.3%
NO	2	4	1.3%	99.7%
DSNOT KN3		1	0.3%	100.0%
Total 300 100.0%				

TABLE 30

AT WHAT AGE SHOULD A CHILD RECEIVE THE MEASES VACCINE?
A QUE EDAD EL NIÑO DEBERIA RECIBIR VACUNA PARA SARAMPION?

		Freq	Percent	Cum.
0		1	0.3%	0.3%
1		1	0.3%	0.7%
2		25	8.3%	9.0%
3		8	2.7%	11.7%
4		5	1.7%	13.3%
5		2	0.7%	14.0%
6		19	6.3%	20.3%
7		2	0.7%	21.0%
9		152	50.7%	71.7%
12		6	2.0%	73.7%
24		4	1.3%	75.0%
72		1	0.3%	75.3%
84		3	1.0%	76.3%
NS 99		71	23.7%	100.0%
Total		300	100.0%	

TABLE 31

WHAT IS THE MAIN REASON FOR A WOMAN TO BE VACCINATED AGAINST
TETANUS?

	P31	Freq	Percent	Cum.
PROTECT MOTHER/CHI	1	108	36.0%	36.0%
PROTEGT ONLY MOTHE	2	38	12.7%	48.7%
PROTEGE ONLY CHILD	3	89	29.7%	78.3%
DSNOT KNOW	4	65	21.7%	100.0%
Total		300	100.0%	

TABLE 32

HOW MANY TT DOSES SHOULD A PREGNANT WOMAN RECEIVE?

P32	Freq	Percent	Cum.
1 ONE	9	3.0%	3.0%
2 TWO	18	6.0%	9.0%
3 MORE T 2	224	74.7%	83.7%
4 NONE	1	0.3%	84.0%
5 DSNOT KN	48	16.0%	100.0%
Total	300	100.0%	

TABLE 33

DO YOU HAVE THE CHILD'S VACCINATION CARD?
TIENE USTED CARNET DE VACUNACION DEL NIÑO?

	Freq	Percent	Cum.
YES 1	272	90.7%	90.7%
LOST IT 2	17	5.7%	96.3%
NO, NEVER 3	11	3.7%	100.0%
Total	300	100.0%	

TABLE 35

DO YOU HAVE AN ANTE-NATAL CONTROL CARD?
 TIENE UD CARNET DEL CONTROL PRENATAL?

		Freq	Percent	Cum.
YES	1	148	49.3%	49.3%
LOST	2	59	19.7%	69.0%
NO	3	93	31.0%	100.0%
Total		300	100.0%	

TABLE 36

REGISTER THE # OF CONTROLS?
 REGISTRE # DE CONTROLES DE LA MADRE

		Freq	Percent	Cum.
ONE	1	4	2.7%	2.7%
TWO OR >	2	142	95.9%	98.6%
NONE	3	2	1.4%	100.0%
Total		148	100.0%	

TABLE 37

DO YOU HAVE A TT VACCINE CARD?
 TIENE UD CARNET DEL TT

		Freq	Percent	Cum.
YES	1	202	67.3%	67.3%
LOST	2	62	20.7%	88.0%
NO	3	36	12.0%	100.0%
Total		300	100.0%	

TABLE 38

REGISTER THE # OF DOSES OF TT?
 REGISTRE # DE DOSIS DE TT

		Freq	Percent	Cum.
ONE	1	9	4.5%	4.5%
TWO OR >	2	192	95.0%	99.5%
NONE	3	1	0.5%	100.0%
Total		202	100.0%	

TABLE 39

85

DO YOU KNOW WHAT DENGUE FEVER IS?
 SABE UD QUE ES EL DENGUE?

	Freq	Percent	Cum.
YES1	265	88.3%	88.3%
NO 2	35	11.7%	100.0%
Total	300	100.0%	

TABLE 40

WHAT DO YOU DO TO CONTROL THE VECTOR OF DENGUE FEVER?

	P40	Freq	Percent
DSNOT KNOW	4	12	2.2%
WASH WATER BIN	1	157	29.2%
ELIMINATE CONT	2	195	36.3%
COVER CONTAIN	3	108	20.1%
OTHER	5	65	12.2%
Total		537	100%

TABLE 40a

OTHER WAYS TO CONTROL TRANSMISSION
 OTRAS FORMAS DE CONTROLAR EL TRANS.

		Freq	Percent	Cum.
HYGIENE	58.5%	38	58.5%	
ELIMINATE TRASH	63.1%	3	4.6%	
ELIMINATE MOSQUITOES	64.6%	1	1.5%	
AVOID TRASH	66.2%	1	1.5%	
AVOID POODLES	69.2%	2	3.1%	
AVOID POODLES	72.3%	2	3.1%	
FUMIGATE	92.3%	13	20.0%	
INSECTICIDE		2	3.1%	

USE SPECIAL PILLS	95.4%		1	1.5%
BURN OLD TIRES	96.9%		1	1.5%
USE INSECTICIDE	98.5%		1	1.5%
	100.0%			
-----+-----				
		Total	65	100.0%

TABLE 41

ARE YOU PREGNANT NOW?
ESTA UD AHORA EMBARAZADA?

			Freq	Percent	Cum.
-----+-----					
YES	1		15	5.0%	5.0%
NO	2		282	94.0%	99.0%
DSNOT KN3			3	1.0%	100.0%
-----+-----					
		Total	300	100.0%	

TABLE 42

WOULD YOU LIKE ANOTHER CHILD IN THE NEXT TWO YEARS?
QUISIERA UD TENER OTRO HIJO EN PROXIMOS
DOS AÑOS?

			Freq	Percent	Cum.
-----+-----					
YES	1		27	9.5%	9.8%
NO	2		243	85.3%	94.7%
DSNOT KN3			15	5.3%	100.0%
-----+-----					
		Total	285	100.0%	

TABLE 43

ARE YOU USING ANY METHOD TO AVOID A PREGNANCY?

ESTA UD USANDO ALGUN METODO PARA NO
EMBARAZARSE?

	Freq	Percent	Cum.
YES 1	127	49.2%	49.2%
NO 2	131	50.8%	100.0%
Total	258	100.0%	

TABLE 44

WHAT IS THE MAIN METHOD YOU USE?
CUAL ES EL METODO PRINCIPAL QUE USAN?

	Freq	Percent	Cum.
LIGATION 1	33	26.2%	26.2%
PILLS 3	33	26.0%	52.4%
IUD 4	40	31.5%	83.3%
DIAPHRAGM 5	2	1.6%	84.9%
CONDOM 6	17	13.4%	98.4%
EXCL BREASTFE 8	1	0.8%	99.2%
ABSTINENCE 10	1	0.8%	100.0%
Total	127	100.0%	

TABLE 45

HOW SOON SHOULD A WOMAN VISIT A DOCTOR IF PREGNANT?
A LOS CUANTOS MESES DE EMBARAZO DEBE VISITAR AL MEDICO?

	Freq	Percent	Cum.
1ST TRIMESTER 1	277	92.3%	92.3%
2ND TRIMESTER 2	11	3.7%	96.0%
3RD TRIMESTER 3	4	1.3%	97.3%
DSNOT KNOW 5	8	2.7%	100.0%
Total	300	100.0%	

TABLE 46

DID YOU VISIT ANY HEALTH CENTER?

VISITO ALGUN CENTRO DE SALUD?			
	Freq	Percent	Cum.
YES 1	271	90.3%	90.3%
NO 2	29	9.7%	100.0%
Total	300	100.0%	

TABLE 47

WHERE DID YOU RECEIVE ANTE-NATAL CONTROL?
DONDE OBTUVO SU CONTROL PRENATAL?

	Freq	Percent	Cum.
CESAMO	4	1.5%	1.5%
CESAMO ALONZO SUAZO	9	3.3%	4.8%
CESAMO IN COMAYAGUA	1	0.4%	5.2%
CESAMO IN DANLI	1	0.4%	5.5%
CESAMO IN MARALES	1	0.4%	5.9%
CESAMO IN OLANCHO	2	0.7%	6.6%
CESAMO IN PESPIRE	1	0.4%	7.0%
CESAMO IN SUYAPA	1	0.4%	7.4%
CESAMO IN TATUMBLA	1	0.4%	7.7%
CESAMO IN BOSQUE	2	0.7%	8.5%
CESAMO IN MACHEN	1	0.4%	8.9%
CESAMO IN MANCHEN	12	4.4%	13.3%
CESAMO IN PEDREGAL, & CLINIC	1	0.4%	13.7%
CESAMO FLOR DEL CAMPO	1	0.4%	14.0%
CESAMO LAS BRISAS	1	0.4%	14.4%
CESAMO LOS PINOS	1	0.4%	14.8%
CESAMO NICARAGUA	1	0.4%	15.1%
CESAMO PAZ BARAHONA	1	0.4%	15.5%
CESAMO SAN MIGUEL	1	0.4%	15.9%
CESAMO SAN MIGUEL	119	43.9%	59.8%
CESAMO SAN MIGUEL, & CLINIC	1	0.4%	60.1%
CESAMO VILLADELA	2	0.7%	60.9%
CESAMO 3 DE MAYO	1	0.4%	61.3%
PRIVATE CLINIC	1	0.4%	61.6%
PRIVATE CLINIC	46	17.0%	78.6%
PRIVATE CLINIC	1	0.4%	79.0%
PRIVATE CLINIC	1	0.4%	79.3%
HOSPITAL IN CHOLUTeca	1	0.4%	79.7%
HOSPITAL EL CARMEN	1	0.4%	80.1%

HOSPITAL HOSPIMED	1	0.4%	80.4%
PRIVATE HOSPITAL	1	0.4%	80.8%
HOSPITL SAN FELIPE	1	0.4%	81.2%
SOCIAL SECURITY HOSP. (IHSS)	50	18.5%	99.6%
IHSS & CESAMO SAN MIGUEL	1	0.4%	100.0%
-----+-----			
Total		271	100.0%

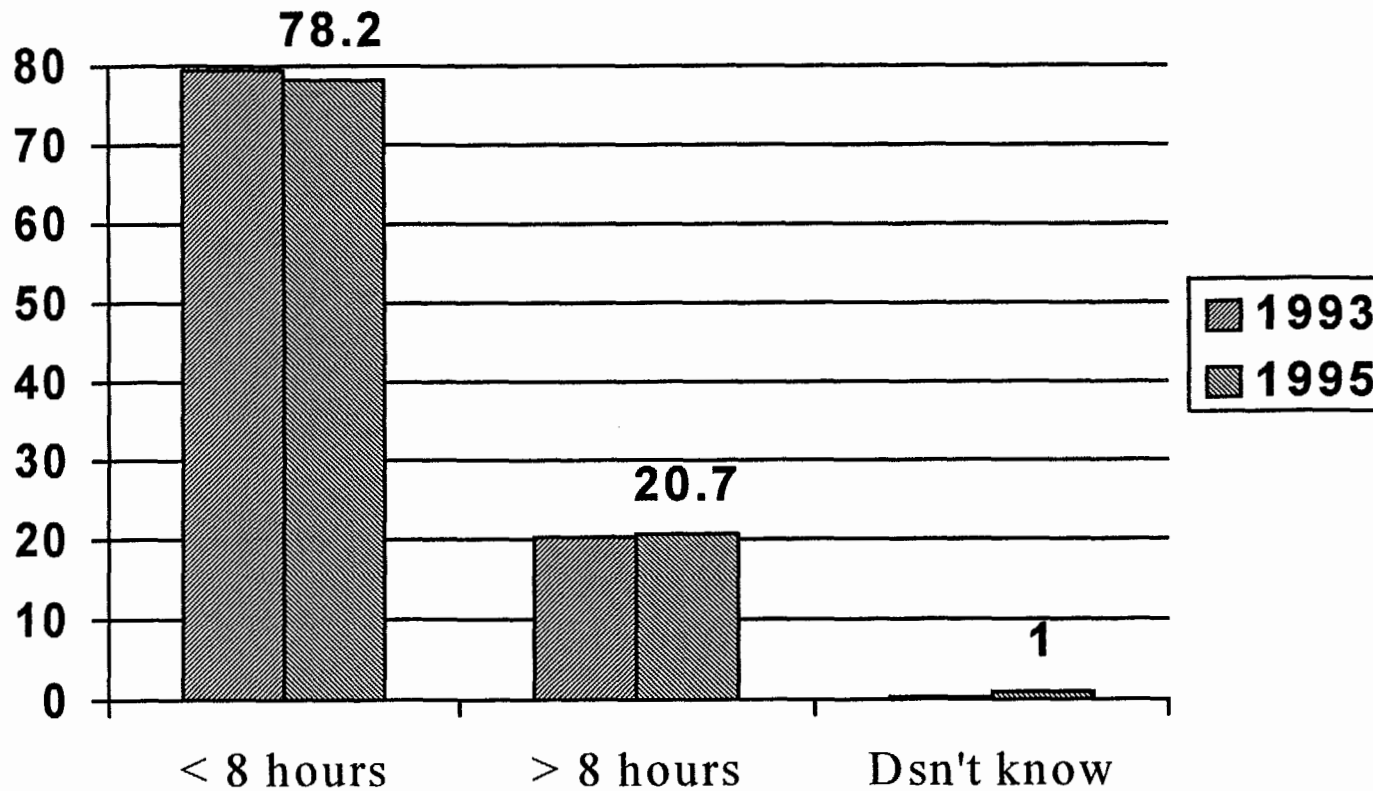
TABLE 48

WHO TIED AND CUT YOUR CHILD'S UMBILICAL CORD?
QUIEN ATO Y CORTO EL CORDON?

		Freq	Percent	Cum.
-----+-----				
A FAMILY MEMBERAM	2	2	0.7%	0.7%
MIDWIFE	3	15	5.0%	5.7%
HEALTH WORKER	4	280	93.3%	99.0%
DSNOT KNOW	5	3	1.0%	100.0%
-----+-----				
Total		300	100.0%	

APROPRIATE NUTRITIONAL PRACTICES

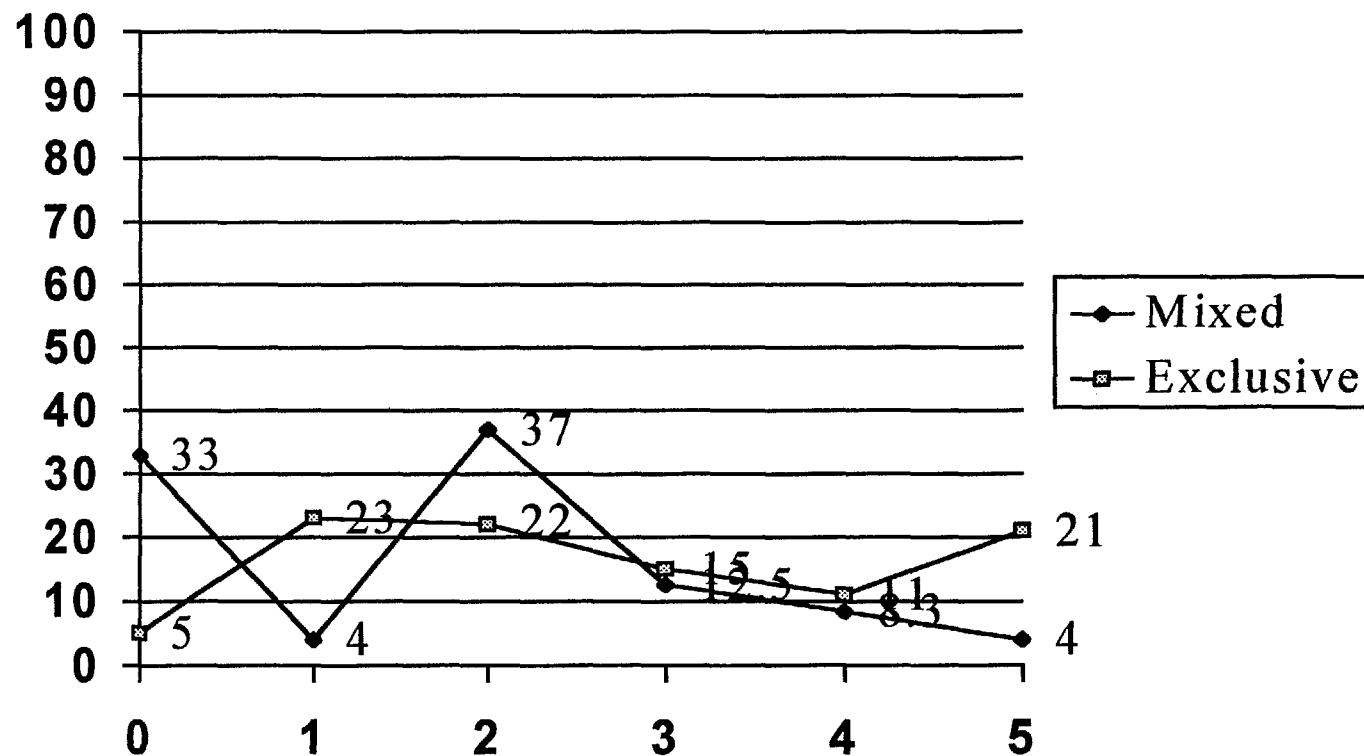
CSP - CESAMO SAN MIGUEL



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APROPRIATE NUTRITIONAL PRACTICES
EXCLUSIVE/MIXED BREASTFEEDING
CSP - CESAMO SAN MIGUEL



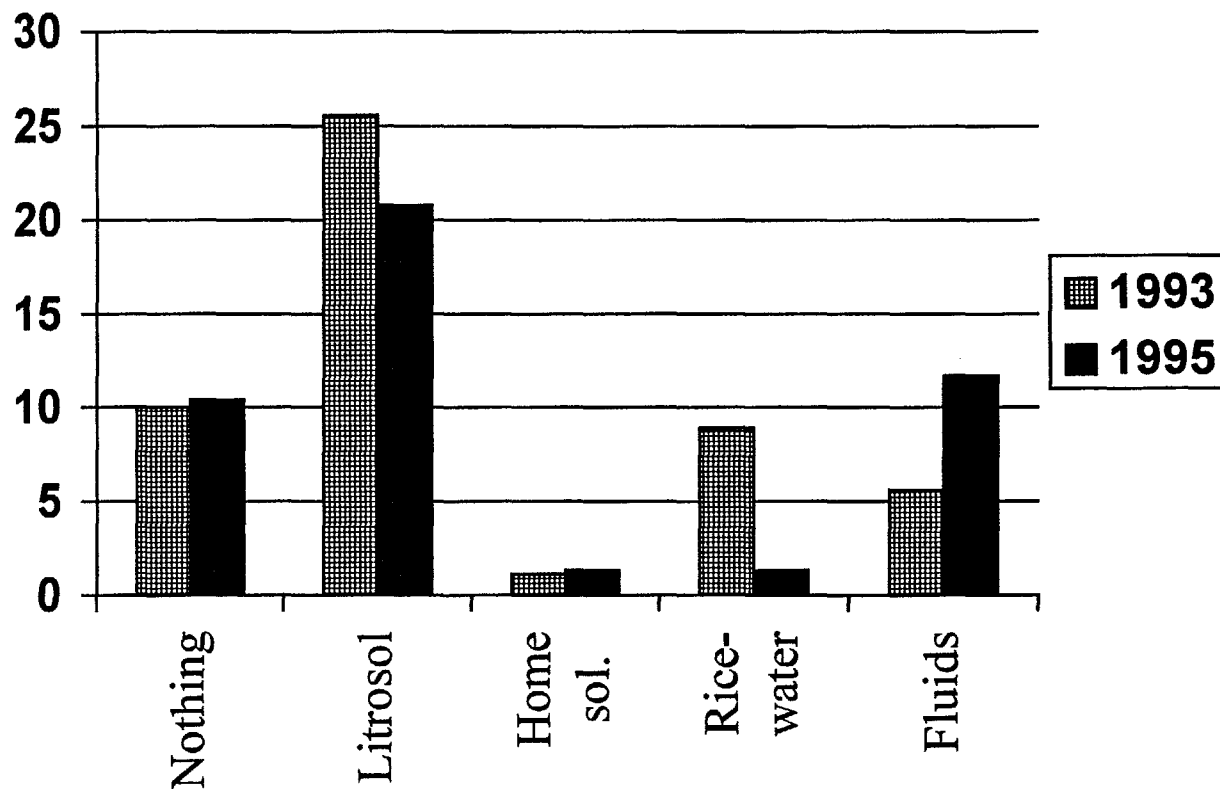
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MANAGEMENT OF THE CHILD WITH DIARRHEA

USE OF ORT

CSP - CESAMO SAN MIGUEL



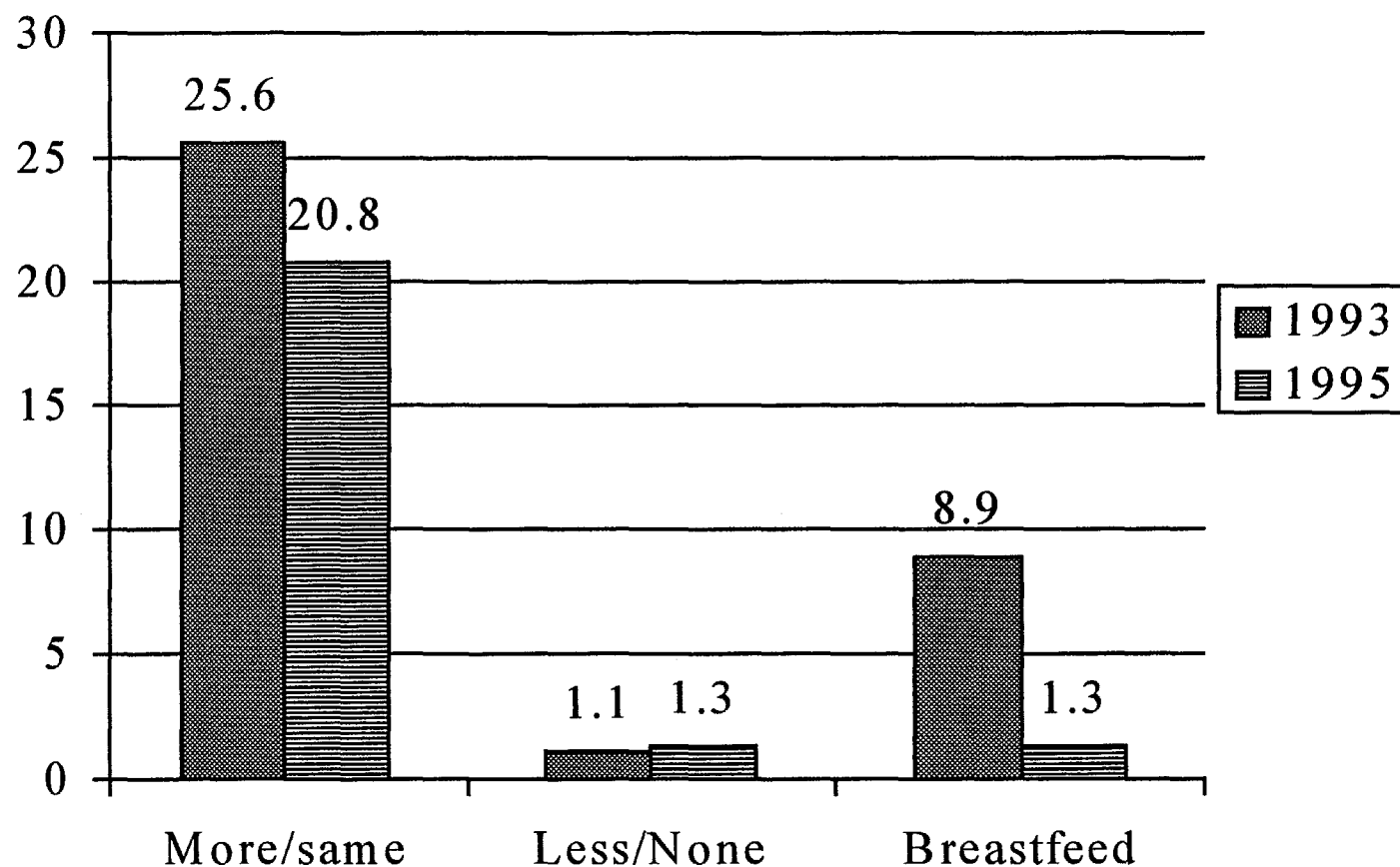
WORLD VISION - HONDURAS SEPT-1995

A-74
GB

MANAGEMENT OF THE CHILD WITH DIARRHEA

FLUIDS MAINTENANCE

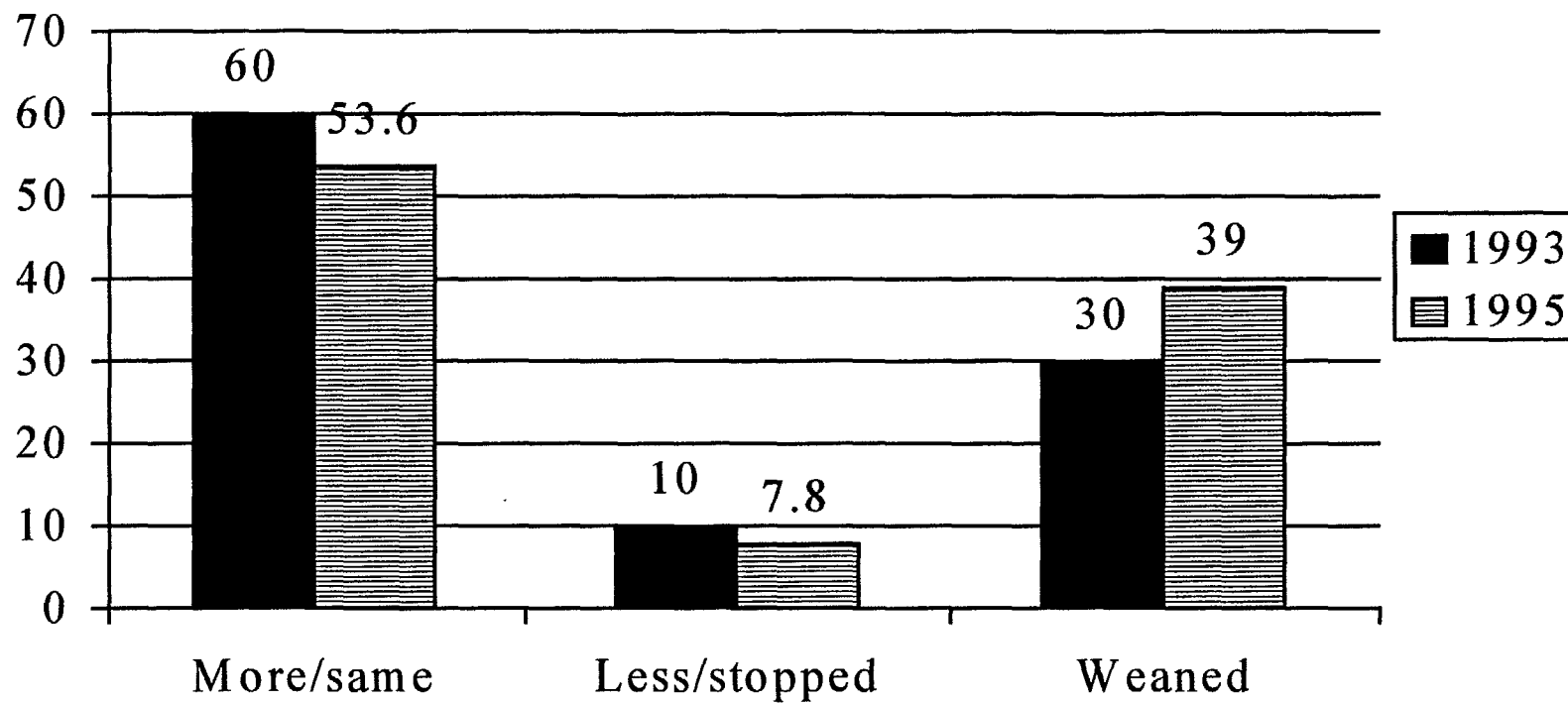
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

17-75
94

MANAGEMENT OF THE CHILD WITH DIARRHEA
CONTINUATION OF BREASTFEEDING
CSP - CESAMO SAN MIGUEL



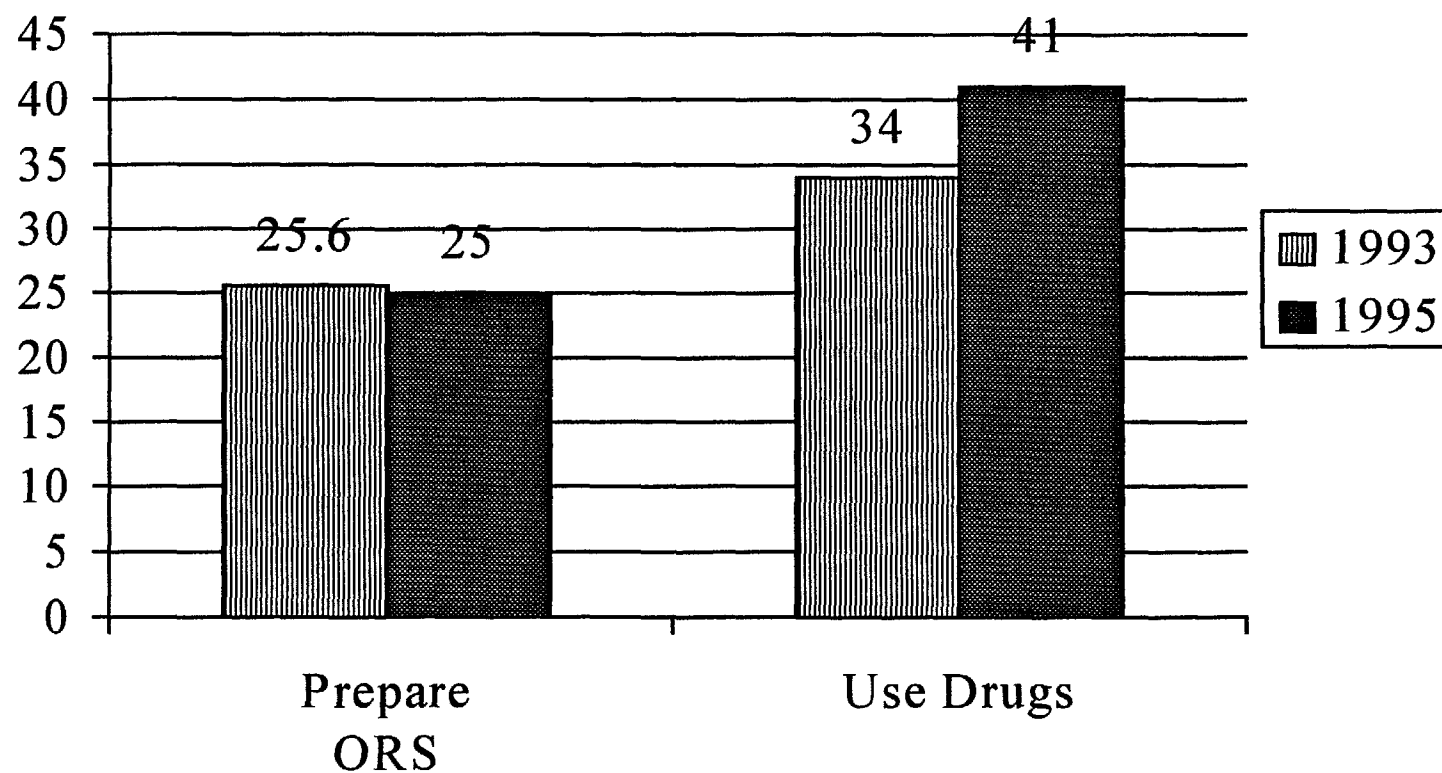
WORLD VISION - HONDURAS SEPT-1995

A-76
90

MANAGEMENT OF THE CHILD WITH DIARRHEA

USE OF ORS - DRUGS

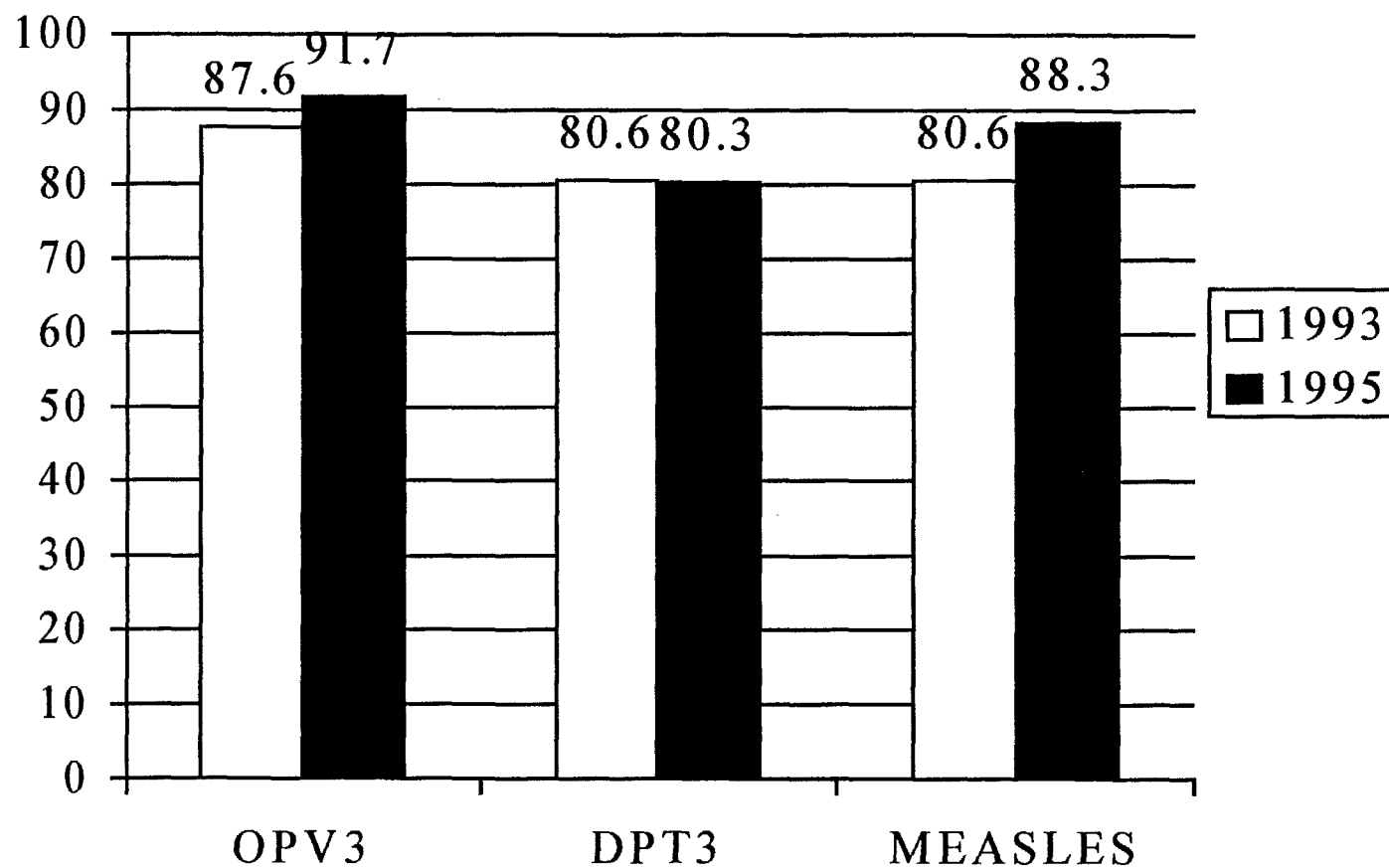
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

14-777
9/6

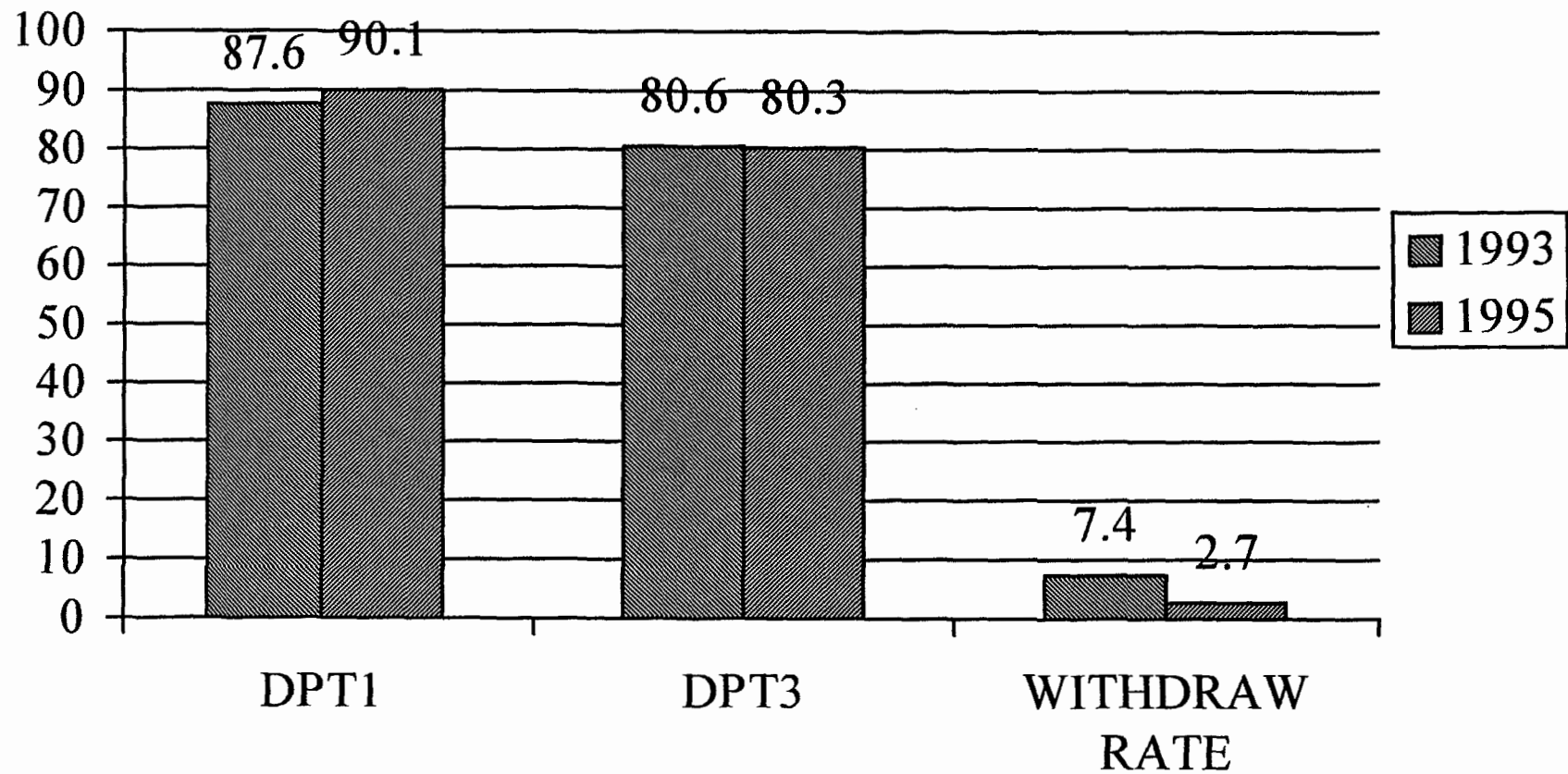
VACCINATION COVERAGE
CHILDREN 12 TO 23 MONTHS: COVERAGE/ACCESS
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

91
A-78

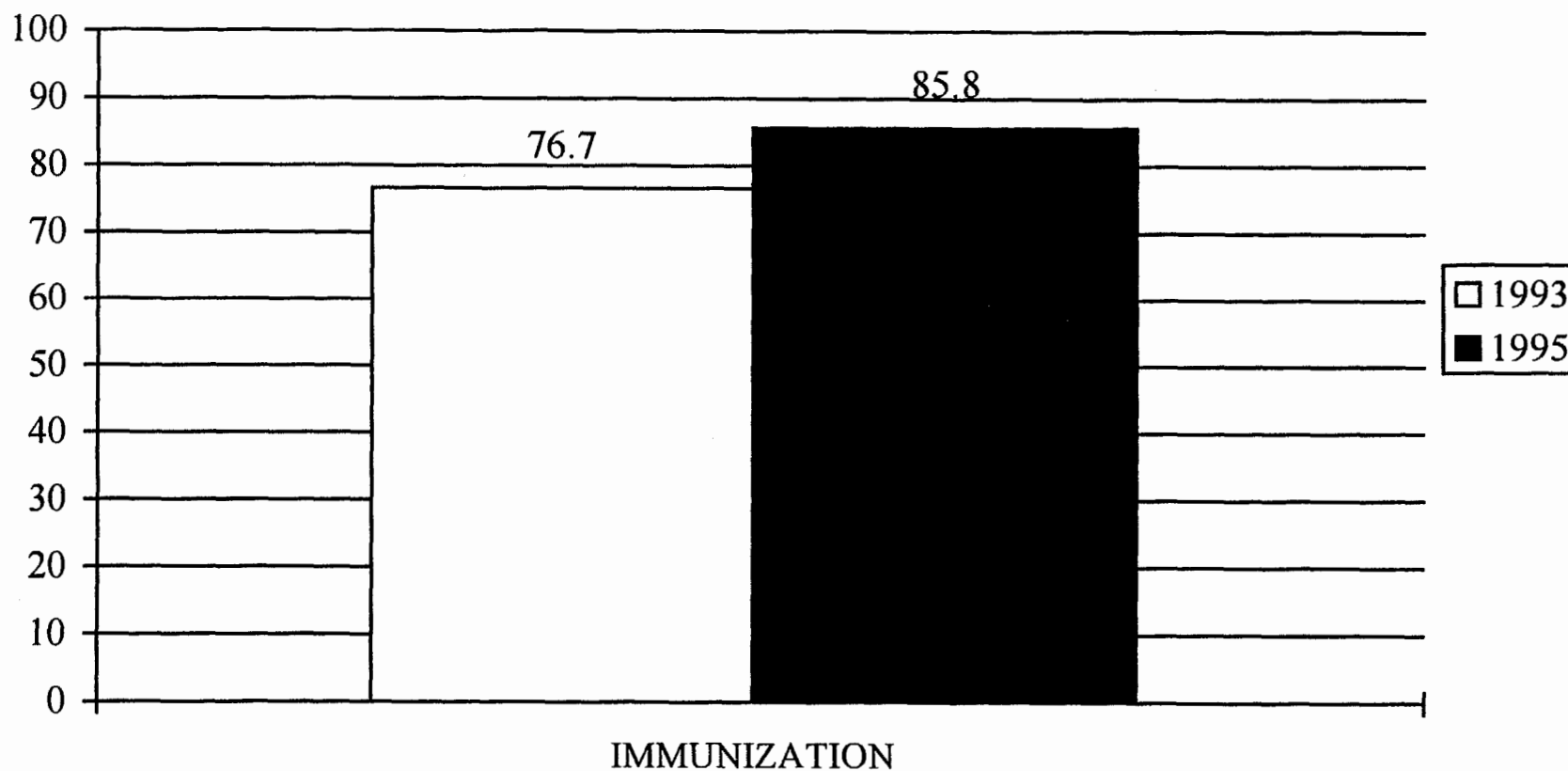
VACCINATION COVERAGE
CHILDREN 12 TO 23 MONTHS: WITHDRAW RATE
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

14-79
98

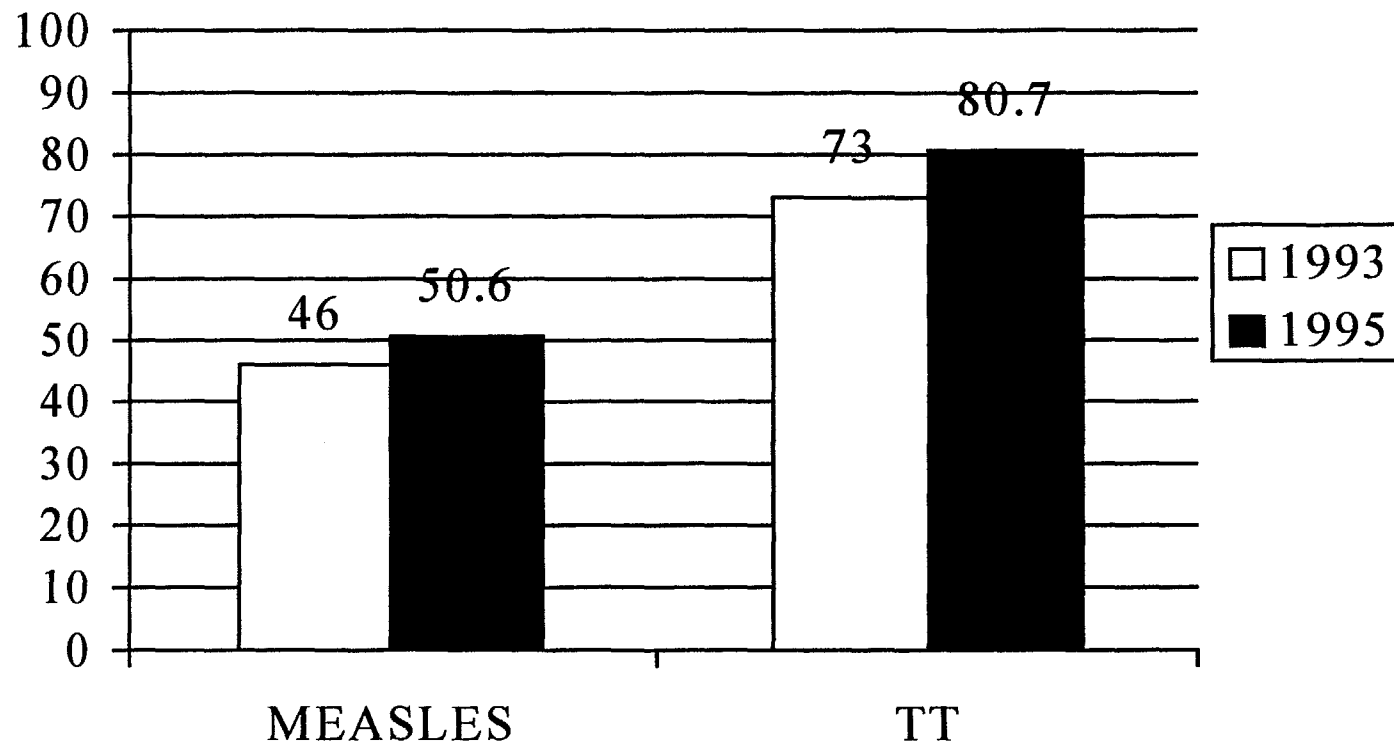
VACCINATION COVERAGE
CHILDREN 12 TO 23 MONTHS: FULL IMMUNIZATION
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

A-80
99

VACCINATION KNOWLEDGE
MOTHERS AWARE OF THE TIME AND NUMBER OF VACCINES
CSP - CESAMO SAN MIGUEL

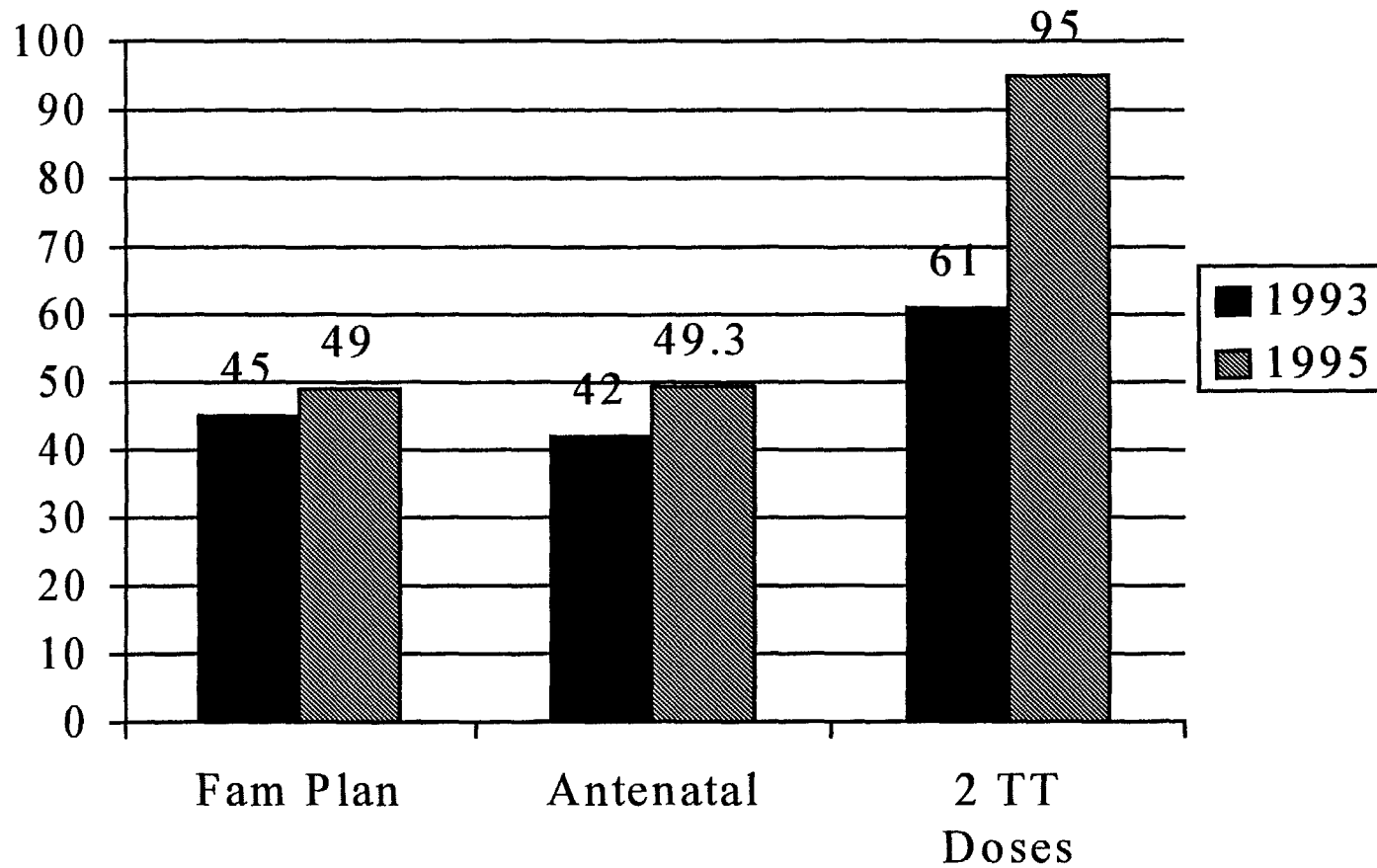


WORLD VISION - HONDURAS SEPT-1995

17-81
100

MATERNAL HEALTH COMPARATIVE GOALS

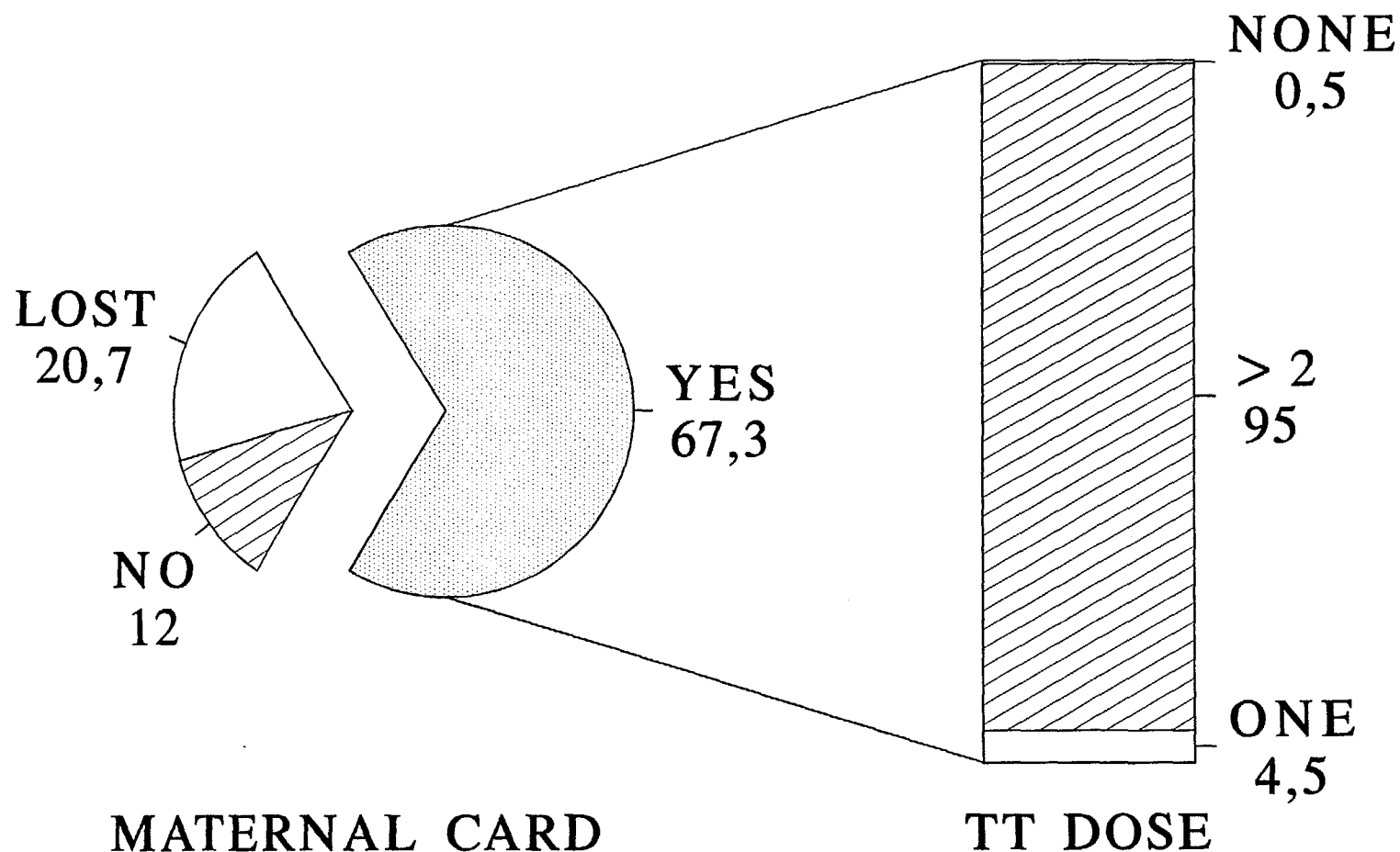
CSP - CESAMO SAN MIGUEL



WORLD VISION - HONDURAS SEPT-1995

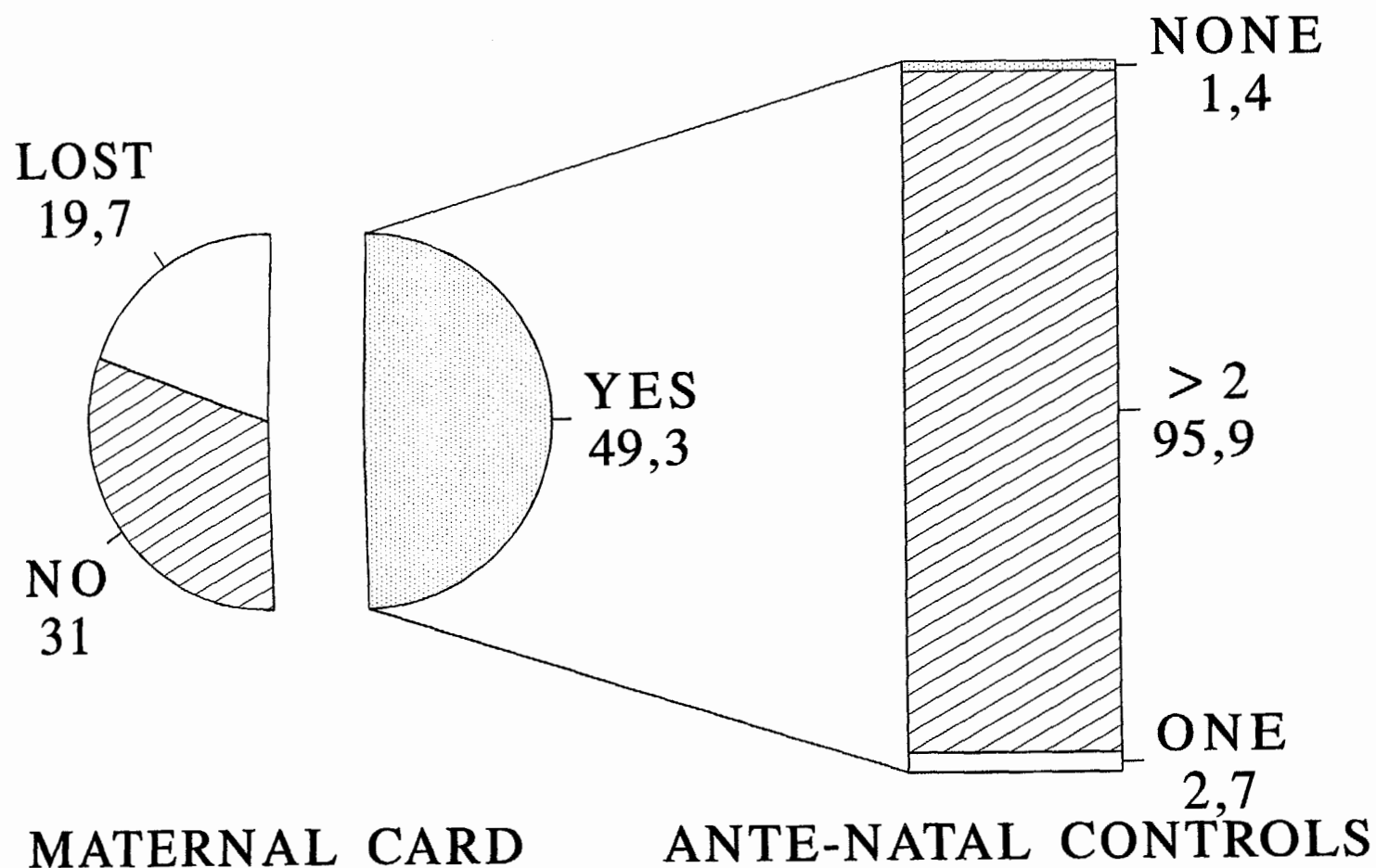
MATERNAL HEALTH: CONTROL CARD

Coverage for TT



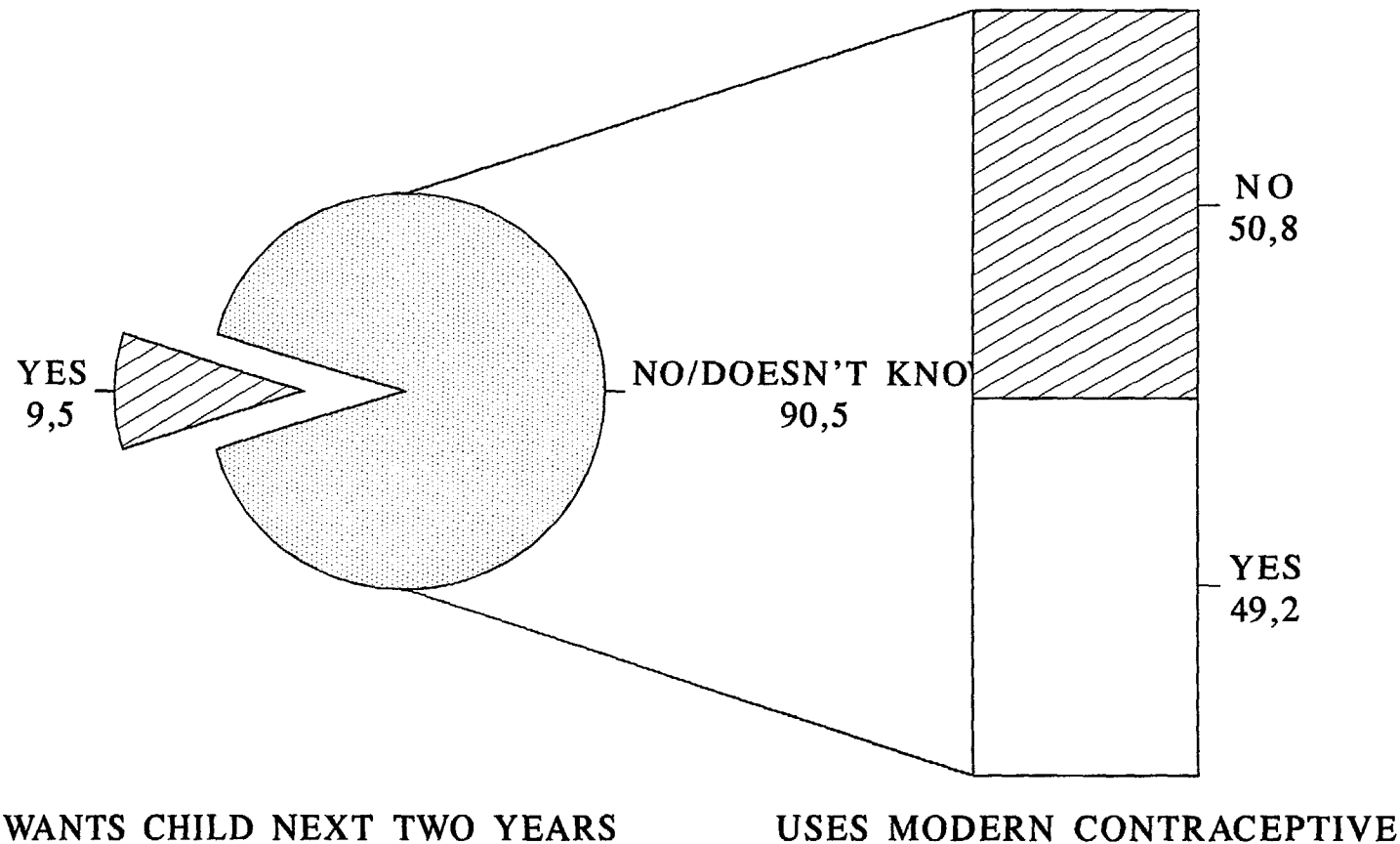
MATERNAL HEALTH: CONTROL CARD

Ante-natal Visits



MATERNAL HEALTH

Use of Modern Contraceptives



WORLD VISION - HONDURAS SEPT-95

19-85
1994

- => If a response seems to be inconsistent with previous information provided by the interviewee, you are right not to believe it. Try to find the truth by asking another question or by rephrasing slightly differently. However, do not be too persistent. A person may change a response only because the persistent questions suggest to her that the interviewer is not satisfied with the answer.

- => When talking to a person, if she presents herself as negative to provide information, do not press her to collaborate and look for another mother who will be willing to complete the interview.

ANNEX No. 9

SUPERVISOR RESPONSIBILITIES

- => Ensure interviewer about conducting the survey; answer their questions.
- => Identify the household clusters to be surveyed.
- => Monitor the interviewers' job:
 - Observe 5% of the interviews.
 - Verify the survey document looking for errors and inconsistencies.
- => Identify and solve the problems (for example, teach an interviewer that he is asking a question or registering data in a wrong way; tell him/her how to do it right)
- => Provide feedback to the interviewers on their performance
- => Help and report to the coordinator.

INTERVIEWEES' RESPONSIBILITIES

- => Proceed with the standard selection of households where the survey will take place.
- => Obtain consent from the families to be interviewed.
- => Use a standard questionnaire for the survey.
- => Register the answers obtained:
 - Review the questionnaire just as you finish asking for information and before you leave the household.
 - At the end of the day, report to the supervisor on the performed duties and give him/her the filled questionnaires
 - Re-interview if the information was not complete.

ATTENDANCE LIST

#	NAME	INSTITUTION	D I A S			
			1	2	3	4
1	José Iris Vásquez C.	World Vision	x	x	x	
2	Onán Saúl Durón Aguilar	CESAMO San Miguel	x	x	x	
3	Orlando Reyes Aguilar	World Vision	x	x	x	
4	Mario Arturo Guevara O.	Proy. El Rosario	x	x	x	
5	Julio César Rodríguez	P.D.A. Yoro	x	x	x	
6	Sunilda Alvarez	P.D.A. Yoro	x	x	x	
7	Ignacio Meza Pérez	P.D.A. Yam.III VM	x	x	x	
8	Miguel Angel Osorio	U.P.S. San Miguel	x	x	x	
9	Victorín Nuñez	CESAMO San Miguel	x	x	x	
10	Efrén Antonio Girón	World Vision	x	x	x	
11	María Concepción Soto	CESAMO San Miguel	x	x	x	
12	Lorena Rosibel Aguilar	CESAMO San Miguel	x	x	x	

Appendix B

PVO/COUNTRY
COOPERATIVE AGREEMENT NO:

World Vision Relief & Development/Honduras
FAO-0500-00-2042-00

PIPELINE ANALYSIS

	Agreement Budget 8/31/92 to 03/31/96		Actual Expenditures 8/31/92 to 09/30/95		Projected Expenditures 10/01/95 to 03/31/96		Spending Variation 10/01/92 to 03/31/96	
	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
I. DIRECT COSTS								
A. PERSONNEL	181,488	0	149,054	0	29,424	0	3,011	0
B. TRAVEL PER DIEM	78,822	0	107,900	0	6,725	0	(35,803)	0
C. CONSULTANTS	31,668	0	13,048	0	4,487	0	14,133	0
D. PROCUREMENT								
1. Supplies	36,712	39,708	36,279	0	6,364	13,749	(5,931)	25,959
2. Equipment	1,120	59,357	0	87,775	0	0	1,120	(28,418)
SUBTOTAL-PROCUREMENT	37,832	99,065	36,279	87,775	6,364	13,749	(4,811)	(2,459)
E. OTHER DIRECT COSTS								
1. Communications	16,620	0	6,496	0	960	0	9,165	0
2. Facilities	2,500	0	3,705	0	324	0	(1,529)	0
3. Other	20,190	0	3,351	0	1,004	0	15,835	0
SUBTOTAL-OTHER DIRECT	39,310	0	13,552	0	2,288	0	23,471	0
TOTAL-DIRECT COSTS	369,120	99,065	319,833	87,775	49,287	13,749	0	(2,459)
II. INDIRECT COSTS								
1. HQ Indirect Costs (20%)	71,880	5,209	63,967	0	7,913	2,750	0	2,459
2. Field Administrative Support	0	159,540	0	137,503	0	22,037	0	0
TOTAL INDIRECT COSTS	71,880	164,749	63,967	137,503	7,913	24,787	0	2,459
GRAND TOTAL	441,000	263,814	383,800	225,278	57,200	38,536	0	0